APPLICATION FOR LICENSURE AND/OR EXAMINATION

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

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SEP 09 2022
IDFPR - MEDICAL UNIT

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE and/or EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

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AUG 04 2022
MAILROOM
SPRINGFIELD

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.

B. FEES ARE NOT REFUNDABLE.

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. **Check the box indicating the appropriate information regarding your application.** ☐ **Military** ☐ **Military Spouse** ☐ **Not Military** ☐ **Decline to Answer**
Military service member is defined as: "Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application." The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

B. SEE **REFERENCE SHEET, CHART I, OR INSTRUCTIONS** PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Medical Resident	188	non-exam	$ 100.00

C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☑ This is the first time I have made application for this profession in Illinois.
- ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: _____
- ☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- ☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
Rienstra-Bareman, Miriam Janelle	MD, MPH	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
[redacted]

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)
Rienstra

7. MOTHER'S MAIDEN NAME
[redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY
[redacted]

9. DATE OF BIRTH
[redacted]
Month Day Year

10. AGE
☑ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: (616) 826 - 3352 (Area Code)
Home: ( ) (Area Code)
Fax: ( ) (Area Code)
Fax: ( ) (Area Code)

12. **REQUIRED** E-MAIL ADDRESS
[redacted]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov

NAME (Last, First, MI):

SS#:

Profession:

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 12

Graduated High School? ☑ Yes ☐ No

Received OR G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
Grand Rapids Christian high	Grnad Rpaids, MI	05 / 2011 (Month / Year)

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 8

Graduated? ☑ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
Calvin College	Grand Rapids, MI	08/2011	05/2015	[redacted]
MSU College of Human Medicine, MPH degree	East Lansing, MI	05/2015	09/201	
MSU College of Human Medicine	Grand Rapids	08/2016	05/2020	

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
Munson Family Residency	Travese City MI	07/2020	06/2023	☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

SS#:

Profession:

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing. Michigan	medical resident	4351046286	07/2020	active
Other States of Licensure				
North Carolina	Visiting resdient license	311070	07/2022	completed

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
USMLE Step 3	MI	02/2022	(Pa[redacted]
USMLE step 2	MI	summer/201	
USMLE step 1	MI	summer/201	

(If additional space is needed, attach a separate sheet.)

NAME (Last, First, MI):

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*		✓
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		✓
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		✓
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*	[redacted]	
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		✓
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		✓

PART VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes

b) CHART III - Select the examination site you desire and enter Test Center Code:

c) CHART IV - Find your School of Graduation and enter school code: 002290

d) Record the number of times you have taken this exam in Illinois or any other state: 0

SS#:

PART VIII: Child Support and Tax Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order?
   (NOTE: If you are not subject to a child support order, answer "no.") [redacted]

2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

   Are you delinquent in the filing of state taxes? [redacted]

Profession:

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted]
Signature of Applicant

7/27/2022
Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION** **PERSONAL HISTORY INFORMATION**	SUPPORTING DOCUMENT **PH**

NAME LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
Rienstra-Bareman, Miriam Janelle			484 - 21 - 2632

In order for your application to be evaluated, you must respond to each of the following questions:	YES	NO
1. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity? If yes, attach a separate sheet with complete and accurate explanation.		✓
2. Have you ever resigned in lieu of discipline or while under investigation that could lead to any restriction, suspension, or termination by any hospital or health care entity? *If yes, attach a separate sheet with complete and accurate explanation.*		✓
3. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended? You must answer yes if any of these actions are currently pending or if you have withdrawn or failed to proceed with an application for privileges/memberships. *If yes, attach a separate sheet with complete and accurate explanation AND request the hospital or health care facility to submit a report directly to the Department regarding the action.*		✓
4. Has your provider status ever been restricted, suspended or terminated by any insurance carrier, including but not limited to Medicare, Medicaid, Tricare or any private carrier? If yes, attach a separate sheet with complete and accurate explanation.		✓
5. Have you ever voluntarily surrendered a license to practice medicine in any state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		✓
6. Have you ever withdrawn an application for a license to practice medicine or any temporary/resident license in any other state, country, or U.S. federal jurisdiction? *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		no
7. Have you ever been admonished, reprimanded, censured and/or disciplined in any way by any professional or medical society or association or committee thereof, or by any non-licensing governmental agency including but not limited to any governmental assistance agency? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Disclose any stipulation to informal disposition in response to this question. *If yes, attach a separate sheet with a complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.*		✓

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted]

Signature of Applicant

07/27/2022

Date

IMPORTANT NOTICE: Completion this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE
Miriam Rienstra-Bareman, Janelle

3. PROFESSIONAL LICENSE NUMBER (if any)
5315216898

2. ADDRESS STREET CITY STATE ZIP CODE
[redacted]

4. SOCIAL SECURITY NUMBER
[redacted]

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturists
- ☐ Advanced Practice Nurses
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☑ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☑
2) Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration?	☐	☑
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☑
4) Are you currently charged with or have you been convicted of a forcible felony? *	☐	☑

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted]
Signature of Applicant

10/18/2022
Date

Rienstra-Bareman

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CASH SECTION
OCT 07 2022

DO paper suppp

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF ACCEPTANCE AND ENROLLMENT FOR A VISITING RESIDENT PERMIT

IDFPR Div. of Professional Regulation

SUPPORTING DOCUMENT **VRP**

1 8 8
Profession Code

NOTE: *An applicant shall not commence limited specialty/residency training before the program receives written notification from the Department of Financial and Professional Regulation.*

APPLICANT: ***Complete Sections 1-3 of this form and forward it to the hospital/institution where you are currently enrolled in residency training.***

484 21 2632

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
Rienstra - Bareman	Miriam	Janine	[redacted]	[redacted]

OUT-OF-STATE PROGRAM DIRECTOR: ***Complete Parts A-G, sign, affix official seal and return to the applicant.***

A. HOSPITAL / INSTITUTION NAME: Munson Medical Center

B. BEGINNING DATE: 06/15/2020 (Month Day Year)

C. ENDING DATE: 06/01/2023 (Month Day Year)

D. BUSINESS ADDRESS (STREET, CITY, STATE, ZIP CODE): 1100 Medical Campus Dr Traverse City MI 49684

E. SPECIALTY / RESIDENCY NAME: Family Medicine

F. BUSINESS TELEPHONE NUMBER: Area Code (231) 935-6000

G. CHECK THE BOX BELOW IF THE PROGRAM IS AFFILIATED WITH THE ILLINOIS FACILITY.

☐ THE RESIDENCY PROGRAM IS AFFILIATED WITH THE ILLINOIS FACILITY.

I do hereby declare that the above-named applicant is a resident in good standing in the above ACGME/AOA accredited training program.

[redacted]
Signature of Program Director

J. William Rawlins DO
Print Name of Program Director

9/22/22
Date

ILLINOIS PROGRAM: *Complete the remainder of this form, sign, affix official seal or notary seal and submit with the application for the above-named applicant.*

A. PATIENT CARE CLINIC OR FACILITY NAME	B. BEGINNING DATE (Month Day Year)	C. ENDING DATE (Month Day Year)
Planned Parenthood of Illinois	12/06/2022	06/06/2023
D. BUSINESS ADDRESS (STREET, CITY, STATE, ZIP CODE)	**E. SPECIALTY / RESIDENCY NAME**	**F. YEAR OF POSTGRADUATE TRAINING**
18 S. Michigan Ave, 16th floor. Chicago, IL 60603	Family Planning	2022-2023
G. BUSINESS TELEPHONE NUMBER	**H. BUSINESS FAX NUMBER**	
Area Code (312) 592-6800	Area Code (312) 592-6801	

I do hereby declare that the above-named applicant has been accepted for limited specialty/residency training in Illinois as indicated above for a period not to exceed six (6) months. I further hereby declare that I assume full supervisory responsibility for the individual during the period specified.

CLINIC FACILITY OFFICIAL SEAL

DANIELLE YOUNG
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
February 04, 2026

[redacted]
Signature of Illinois Supervising Physician

Virgil Reid 036-102311
Type or Print Name of Illinois Supervising Physician and IL License #

10/4/2022
Date

RECEIVED
OCT 13 2022

IL486-1906 02/10 (MD)

IDFPR - MEDICAL UNIT

Program Letter of Agreement ("PLA")

This document serves as an Educational Agreement between **Munson Family Practice Residency Program** (MFPR), Munson Medical Center (MMC) and Midwest Access Project, involved in resident education.

This Letter of Agreement is effective from 12/01/2022 and will remain in effect for five years unless updated, changed or terminated by the Residency Program or Midwest Access Project, a, "Host".

Persons Responsible for Education and Supervision

At Residency Program:	J. Wm. Rawlin, D.O. Program Director Munson Family Practice Clinic 1400 Medical Campus Drive Traverse City, MI 49684 (231) 935-8012
At Participating Site:	Midwest Access Project 5215 North Ravenswood Avenue, Suite 206 Chicago, IL 60640 Physician: See Attachment B

The above mentioned people are responsible for the education and supervision of the residents while rotating at with Host at a Host's Affiliated Clinical Training Site outlined in Attachment B.

Responsibilities:

It is agreed that:

1. All resident training costs (including salary, benefits and malpractice insurance) will be the responsibility of Munson Medical Center.
2. Munson Medical Center Office of Graduate Medical Education will insure that malpractice insurance for all medical students is supplied by each individual medical school.
3. It is agreed that compensation for teaching physicians efforts will be as follows:
   a. Munson Medical Center Office of Graduate Medical Education will annually track teaching hours and provide a summary when needed for submission by the physician for CME credit.
   b. Munson Medical Center Office of Graduate Medical Education will process an application for faculty status of the teaching physicians with Michigan State University if requested.
4. The faculty at HOST's Affiliated Clinical Training Site shall provide appropriate supervision of residents/fellows in patient care activities and maintain a learning

environment conducive to educating the residents/fellows in the ACGME competency areas. The HOST's Affiliated Clinical Training Site faculty shall evaluate Resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment.

Content and duration of the Educational Experiences

The content of the education experiences has been developed according to ACGME Family Medicine Residency Program Requirements and includes the following:

1. To provide the additional experience necessary for the Residency Program's Residents rotation of Obstetrics as part of their training in Family Medicine. The Goals & Objectives of this medical education learning experience are provided in Attachment A, which is herein incorporated by reference.
2. The durations of the assignments are up to 4-weeks as an elective in a PGY2 or PGY3 training year.
3. In cooperation with the Residency Program, the supervising Faculty at Midwest Access Project and Midwest Access Project's Affiliated Clinical Training Sites is responsible for the day-to-day activities of the Residents to assure that the goals and objectives are met during the course of the medical education learning experience.

Policies and Procedures that Govern Resident Education

Residents are under the general direction of the Program director, who shall require Residents to adhere to the applicable Residency Program and Institution policies and procedures, as well as applicable policies and procedures at Midwest Access Project and Midwest Access Project's Affiliated Clinical Training Sites.

Munson Family Practice Residency Program

[redacted]

J. Wm. Rawlin, D.O., Program Director — Date: 5/26/22

[redacted]

Daniel Webster, M.D., Designated Institution Official — Date: 05/26/2022

Midwest Access Project

[redacted]

Lynne Johnson, JD, Executive Director — Date: 5/27/2022

Attachment A

Goals and Objectives

- Gain confidence with complex contraception consults and treatment plans
- Hone skills with IUD/nexplanon procedures and ultrasounds
- Gain experience with medical and procedural abortion

Attachment B

midwest access project
Filling the Gaps ~Training Providers in Reproductive Health

MAP's Affiliated Clinical Training Sites

Updated January 2022

*All affiliated clinical training sites' professional liability is $1,000,000 per occurrence and $3,000,000 aggregate unless otherwise noted below.

Carafem North Shore Health Center
4711 Golf Rd, Suite 920
Skokie, IL 60076
Medical Director: Mark Hathaway, MD

Hope Clinic for Women
1602 21st Street
Granite City, IL 62040
Medical Director: Erin King, MD

Planned Parenthood of Great Plains
Dep. Medical Director: Laura Laursen, MD
Comprehensive Health Center of Overland Park
4401 W 109th Street #100
Overland Park, KS 66211

Midtown Health Center: Tulsa
205 E. Pine St.
Tulsa, OK 74106

Planned Parenthood of Illinois
Medical Director: Amy Whitaker, MD
Sites may include, but are not limited to:

Near North Health Center
1200 N. LaSalle St.
Chicago, IL 60610

Aurora Health Center
3051 E. New York St.
Aurora, IL 60504

Flossmoor Health Center
19831 Governors Hwy
Flossmoor, IL 60422

Planned Parenthood of Wisconsin
Medical Director: Kathy King, MD
Sites may include, but are not limited to:

Kenosha Health Center
3601 Roosevelt Road
Kenosha, WI 53142

Madison East Health Center
3706 Orin Road
Madison, WI 53704

Madison South Health Center
2222 S. Park Street Suite 210
Madison, WI 53713

Milwaukee-Wisconsin Avenue Health Center
2207 W. Wisconsin Ave
Milwaukee, WI 53233

Milwaukee - Capitol Drive Health Center
801 East Capitol Drive
Milwaukee, WI 53212

Milwaukee - Mitchell Street Health Center
1710 South 7th Street Suite 300
Milwaukee, WI 53204

Milwaukee- Water Street Health Center
435 S. Water Street
Milwaukee, WI 53204

Milwaukee-Northwest Health Center
5380 W Fond du Lac Avenue
Milwaukee, WI 53216

Milwaukee-Lincoln Plaza Health Center
2239 S 108th Street
West Allis, WI 53227

Sheboygan Health Center
909 South Taylor Drive
Sheboygan, WI 53081

University of Chicago Ryan Center
5758 S. Maryland Avenue
Chicago, IL 60637
Medical Director: Amber Truehart MD, MS

midwest access project
Filling the Gaps ~ Training Providers in Reproductive Health

MAP's Affiliated Clinical Training Sites

Updated January 2022

Whole Woman's Health of the Twin Cities
8053 E. Bloomington Freeway Suite #450
Bloomington, MN 55420
Medical Director: Jessika Ralph, MD

Little Rock Family Planning Services
4 Office Park Drive
Little Rock, Arkansas 72211
Medical Director: Tom Tvedten, MD

CHOICES – Memphis Center for Reproductive Health
1726 Poplar Avenue
Memphis, TN 38104
Interim Medical Director: Terry Grebe, MD

Scotsdale Women's Center*
W Seven Mile Road
Detroit, MI 48219
Medical Director: Robert Egan, MD *Scotsdale professional liability is $200,000 per occurrence and $600,000 aggregate.

Just The Pill
2038 Ford Parkway #444
Saint Paul, MN 55116
Medical Director: Julie Amaon, MD

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CERTIFICATION OF ACCEPTANCE AND ENROLLMENT FOR A VISITING RESIDENT PERMIT

SUPPORTING DOCUMENT
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APPLICANT: ***Complete Sections 1-3 of this form and forward it to the hospital/institution where you are currently enrolled in residency training.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
Rienstra-Bareman, Miriam Janelle	[redacted]	[redacted]

OUT-OF-STATE PROGRAM DIRECTOR: ***Complete Parts A-G, sign, affix official seal and return to the applicant.***

A. HOSPITAL / INSTITUTION NAME	B. BEGINNING DATE Month Day Year	C. ENDING DATE Month Day Year
Munson family Practice	07/01/2020	06/25/2023
D. BUSINESS ADDRESS (STREET, CITY, STATE, ZIP CODE)	E. SPECIALTY / RESIDENCY NAME	
1400 Medical campus drive	family medicine	
F. BUSINESS TELEPHONE NUMBER	G. CHECK THE BOX BELOW IF THE PROGRAM IS AFFILIATED WITH THE ILLINOIS FACILITY.	
Area Code (231) 935 — 8000	☐ THE RESIDENCY PROGRAM IS AFFILIATED WITH THE ILLINOIS FACILITY.	

I do hereby declare that the above-named applicant is a resident in good standing in the above ACGME/AOA accredited training program.

[redacted]
Signature of Program Director

J. William Rawlow DO
Print Name of Program Director

7/29/22
Date

ILLINOIS PROGRAM DIRECTOR: ***Complete the remainder of this form, sign, affix official seal or notary seal and submit with the application for the above-named applicant.***

A. PATIENT CARE CLINIC OR FACILITY NAME	B. BEGINNING DATE Month Day Year	C. ENDING DATE Month Day Year
	/ /	/ /
D. BUSINESS ADDRESS (STREET, CITY, STATE, ZIP CODE)	E. SPECIALTY / RESIDENCY NAME	F. YEAR OF POSTGRADUATE TRAINING
G. BUSINESS TELEPHONE NUMBER	H. BUSINESS FAX NUMBER	
Area Code (___) ___ — ____	Area Code (___) ___ — ____	

I do hereby declare that the above-named applicant has been accepted for limited specialty/residency training in Illinois as indicated above for a period not to exceed six (6) months. I further hereby declare that I assume full supervisory responsibility for the individual during the period specified.

CLINIC, FACILITY, OR NOTARY SEAL

Signature of Illinois Supervising Physician

036 -
Type or Print Name of Illinois Supervising Physician and IL License #

Date