Physician and Surgeon Application Summary

Tien, Shelly Hsiao-Ying
[redacted]

4140 27TH Ave S.
MPLS 55406

Birthdate: [redacted]1981 ✓
Birthplace: Amherst, MA USA

Application #: 101346
Application Rec'd: 03/05/2012
Board Date: 07/14/2012
Basis: USMLE
Legal:

PY DOM

Deposit # : H7B-12277
Amt Paid : 491.20

55482

Interviewer: Paul
Interview Date: 6-19-12

Received:	Completed:	
		Exam
02/28/2012	02/28/2012	USMLE1 88 06/10/2005;USMLE2 89 06/18/2007;USMLE3 86 08/06/2010;
		Competency
N/A		
		Medical School
03/05/2012	03/01/2012	TUFTS U Boston MA USA - M.D. 05/18/2008
03/05/2012	03/05/2012	Diploma
		Medical Training
03/05/2012	02/28/2012	Advocate IL Masonic Med Ctr 07/01/2008-06/30/2012 Chicago IL USA OB & GY- Obstetrics & Gynecology DARP PG 482, 2008/09
		Certificate not issued
		Licenses
04/13/2012	04/11/2012	IL, USA 07/31/2014
		Hospital Privileges
N/A		
		Recommendations
03/05/2012	02/28/2012	Brenda Darrell
03/05/2012	03/01/2012	David A. Rojas
		Databank Searches
03/05/2012	03/05/2012	Federation

03/05/2012	03/05/2012	AMA
03/26/2012	03/05/2012	NPDB
03/26/2012	03/05/2012	HIPDB

Miscellaneous

03/05/2012	02/28/2012	Accounting of time
03/05/2012	02/28/2012	Photo
03/05/2012	02/28/2012	Release
03/05/2012	02/28/2012	Malpractice history report None
03/05/2012	02/27/2012	Facilities list None
		Military papers Branch -

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Temporary Permits / Registrations

TP/TR	Number	From:	To:	Approved By:	Date:
TP	106031	4/16/12	7/14/12	[illegible]	4-16-12

APPLICATION TO PRACTICE MEDICINE

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 500
MINNEAPOLIS, MINNESOTA 55414-3246
612-617-2130 or www.bmp.state.mn.us

Hearing Impaired-Minnesota Relay Service 711 or 1-800-627-3529
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

MAR 5 2012 BOARD OF MEDICAL PRACTICE

DATE OF APPLICATION:

MONTH	DAY	YEAR
2	28	2012

FOR BOARD USE ONLY

APPLICATION #: 101346
CHECK/RECEIPT #: 27721
AMT PAID:
TEMP PERMIT #:
BOARD ACTION:
BOARD DATE: 7-14-12
LICENSE #: 55482

ACCOUNT CODE	AMOUNT
635009 lic	192.00
635010 app	200.00
635012 tp	60.00
513122 sur	39.20

INSTRUCTIONS TO APPLICANT

1. Answer all questions completely, accurately, and legibly or the application will be returned.
2. The name you enter must exactly match the name on your medical diploma, or documentation of formal name change must be submitted.
3. All addresses must include zip code if requested on the application.
4. Account for all time from the beginning of high school, whether spent in school, practice, or otherwise. Dates must include Month, Day, and Year. Attach a separate sheet if necessary.
5. Enter all dates as MONTH-DAY-YEAR.
6. The application fee is not refundable.
7. Failure to answer all questions completely and accurately, omission or falsification of material facts, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
8. Incomplete applications may be destroyed after six months of inactivity.

TO: The Minnesota Board of Medical Practice:

I hereby make application for a license to practice medicine and surgery in the State Of Minnesota and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME: LAST	FIRST	MIDDLE
Tien	Shelly	Hsiao-Ying

STREET ADDRESS: 711 West Bordan Terrace, # 301

CITY	STATE OR PROVINCE	ZIP CODE	COUNTRY
Chicago	IL	60613	USA

HOME PHONE: [redacted] OTHER PHONE: [redacted] OTHER NAMES:

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER: [redacted]

GENDER ☐ MALE ☒ FEMALE

BASIS FOR APPLICATION (CHECK ONE)

- ☐ FEDERATION LICENSING EXAMINATION (FLEX)
- ☐ NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINATION (NBME)
- ☐ NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS EXAMINATION (NBOME)
- ☐ COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION (COMLEX-USA)
- ☐ LICENTIATE OF MEDICAL COUNCIL OF CANADA EXAMINATION (LMCC)
- ☐ STATE BOARD EXAMINATION (STATE)
- ☒ UNITED STATES MEDICAL LICENSING EXAM (USMLE)
- ☐ COMBINATION FLEX, NBME, USMLE (MUST BE COMPLETED BY YEAR 2000)

ECFMG CERTIFICATION (FOREIGN ONLY)

NUMBER:
DATE ISSUED:

DRIVER'S LICENSE

STATE: IL
NUMBER: [redacted]

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ADDRESS OF NEAREST RELATIVE	
NAME OF RELATIVE: Shu Tien	
STREET ADDRESS: [redacted]	

YOUR INTENDED ADDRESS (IF KNOWN)		
STREET ADDRESS: unKnown		
CITY:	STATE OR PROVINCE:	
ZIP CODE:	COUNTRY:	EFFECTIVE DATE:
PHONE:		

RECORD OF BIRTH			
[redacted] /DAY/YEAR) 1981	CITY OF BIRTH: Amherst	COUNTY OF BIRTH: USA	STATE/PROVINCE OF BIRTH: MA
FULL NAME OF FATHER: Sien-Heh Tien	MOTHER'S MADEN NAME: Lee	COUNTRY OF BIRTH: Taiwan	

IDENTIFYING CHARACTERISTICS			
HEIGHT (ft./in.): 5/4	WEIGHT (lbs): 105	COLOR HAIR: Black	COLOR EYES: Brown
IDENTIFYING MARKS: none			

PRELIMINARY EDUCATION					
NAME OF HIGH SCHOOL: Libertyville High School	CITY: Libertyville	STATE OR PROVINCE: IL		FROM DATE: (Mo/Day/Year) 8/25/95	TO DATE: (Mo/Day/Year) 6/1/99
NAME OF COLLEGE: Univ. of IL Urbana/Champaign	CITY: Urbana/ Champaign	STATE OR PROVINCE: IL	DEGREE B.S.	FROM DATE: (Mo/Day/Year) 8/25/99	TO DATE: (Mo/Day/Year) 6/15/03
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	DEGREE	FROM DATE: (Mo/Day/Year) / /	TO DATE: (Mo/Day/Year) / /

MEDICAL EDUCATION (MEDICAL COLLEGES MUST BE RECOGNIZED BY THE BOARD)					
INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
Tufts Univ. School of Medicine	Boston	MA	02111	8/23/2003	5/18/2008
				M.D./MPH	

ACCOUNTING OF TIME NOT NOTED ELSEWHERE ON THIS APPLICATION		
ACTIVITY (ATTACH SEPARATE SHEET, IF NECESSARY)	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)

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MEDICAL DIPLOMAS

BACHELOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE Mo/Day/Year
☐ MEDICINE ☐ OSTEOPATHY						
DOCTOR OF OF:	**NAME OF SCHOOL:**	**CITY:**	**STATE OR PROVINCE**	**ZIP:**	**COUNTRY:**	**DATE Mo/Day/Year**
☒ MEDICINE ☐ OSTEOPATHY	Tufts	Boston	MA	02111	USA	5/18/2008

US/CANADIAN ACCREDITED GRADUATE CLINICAL MEDICAL INTERNSHIP, RESIDENCY, FELLOWSHIP

NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
Advocate IL Masonic Medical Center		7/1/2008	6/30/2012	
STREET ADDRESS: 836 W. Wellington Ave	CITY: Chicago	STATE OR PROVINCE: IL	COUNTRY: USA	ZIP CODE: 60657
TYPE OF TRAINING: (BE SPECIFIC) Obstetrics and Gynecology Residency				
NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				

MILITARY SERVICE

BRANCH OF SERVICE:	ENTRY DATE (Mo/Day/Year)	RELEASE DATE (Mo/Day/Year)	RANK AT DISCHARGE:	TYPE OF DISCHARGE
DUTY ASSIGNMENT: not applicable			LOCATION:	

STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE EVER BEEN LICENSED

STATE/PROVINCE/COUNTRY	LICENSE NUMBER	DATE ISSUED (Mo/Day/Year)	HOW OBTAINED(*)
ILLINOIS	036128275	July 2011	as a resident,
	336.090117		applied through mypecognition

(*) NATIONAL BOARD OF MEDICAL EXAMINERS (NBME)
STATE BOARD EXAM (STATE)
NATIONAL BOARD OF OSTEO MEDICAL EXAMINERS (NBOME)
COMPREHENSIVE OSTEO MEDICAL LICENSING EXAM (COMLEX-USA)
FLEX EXAMINATION (FLEX)
UNITED STATES MEDICAL LICENSING EXAM (USMLE)
COMBINATION FLEX, NBME, USMLE (COMB)
LICENTIATE OF MEDICAL COUNCIL OF CANADA (LMCC)

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PRACTICE REFERENCES

STATE BELOW WHERE YOU HAVE PRACTICED OUTSIDE OF A TRAINING PROGRAM, AND LIST TWO REFERENCES FROM EACH FACILITY

NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
I have only practiced in residency.				
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATECNTRY	ZIP CODE:
NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATECNTRY	ZIP CODE:

PROPOSED PRACTICE PLANS IN MINNESOTA (IF ANY)

Fellowship in Maternal Fetal Medicine at the University of Minnesota

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE
ACOG	2008	current

Are you currently* certified by a specialty board of the (check one): None

- ☐ American Board of Medical Specialties
- ☐ Royal College of Physicians and Surgeons of Canada
- ☐ College of Family Physicians of Canada
- ☐ American Osteopathic Assn Bureau of Professional Education
- ☐ None of the above

Specialty: ____________

Issue Date: ____________

Expiration Date: ____________

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

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 questions(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended us 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 renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information.

[redacted]

not applicable #1-4

ognitive, communicative, or physical capability to engage in the practice of medicine or h reasonable skill and safety impaired or limited in any way? Please describe.

a. If yes, are the limitations or impairments reduced or ameliorated because you receive ngoing treatment (with or without medications) or participate in a monitoring program? ease describe.

. If yes, are the limitations or impairments reduced or ameliorated because of the field of actice, the setting, or the manner in which you have chosen to practice? Please describe.

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

engaged in any illegal use of controlled substances including use of illegal controlled s (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained a valid prescription of a licensed health care provider). Please describe.

If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support oup) to discontinue or reduce such use? Please describe.

If yes, are you now participating in a supervised rehabilitation program or professional sistance program which has as a component a monitoring regimen designed to assure that u are not currently engaging in the use of illegal controlled substances? Please describe.

within the past five years been advised by your treating physician that you have a mental, or emotional condition, which, if untreated, would be likely to impair your ability to practice with reasonable skill and safety? If you answer this question 'yes", please answer the

a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?
b. With regard to any condition referenced above, are you in compliance with the recommended treatment?
. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?

4d. Please explain._____

4e. Identify your treating physician._____

[redacted]

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

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.

Have you ever 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.

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.

Have you ever been notified of any investigations 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.

Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents).

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

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, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.

3. 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 chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed.

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

5. Have you ever applied for licensure in Minnesota before? If so, please give license # and issue date or withdrawal/denial date.

6. Have you ever had a residency permit in Minnesota? If so, please give residency permit number. (Residents are required to have residency permits as of 1993 unless licensed in Minnesota).

CERTIFICATE OF ETHICAL AND MORAL CHARACTER

THIS CERTIFICATE MUST BE SIGNED BY TWO LICENSED PHYSICIANS WHO ARE PERSONALLY ACQUAINTED WITH THE APPLICANT.

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Jon M. Simonelli MD.	02 27 12	36 51794	IL

JON M. SIMONELLI, MD.
PRINT OR TYPE FULL NAME

IL

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

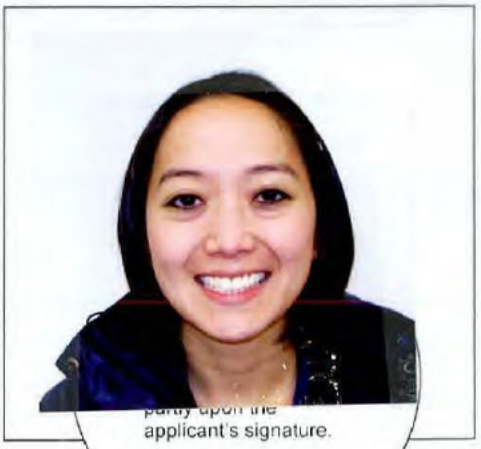
State: ILLINOIS County: COOK

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant on this 28TH day of FEBRUARY, 2012.

Notary Public Signature

Expiration Date 02 / 21 / 2015
Month Day Year

"OFFICIAL SEAL"
GAIL B. ZATOR
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 2/21/2015



applicant's signature.

Shelly Tien
Applicant Signature

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Brenda A Darrell	2/28/2012	[redacted]	IL

Brenda A Darrell
PRINT OR TYPE FULL NAME

55182

AFFIDAVIT OF APPLICANT:

STATE OF: ILLINOIS

COUNTY OF: COOK

I, Shelly Tien, swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota: that I am the person named in the diploma, which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

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 of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this 28TH day of FEBRUARY, 2012.

Signature of Notary Public

Shelly Tien
Signature of Applicant

My Commission Expires: 2-21-2015

"OFFICIAL SEAL"
GAIL B. ZATOR
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 2/21/2015

RIGHTS OF SUBJECTS OF DATA

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

US·MLE
United States
Medical
Licensing
Examination

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4041

Date : 02/28/2012

Recipient:

Minnesota Board of Medical Practice
ATTN: Robert A Leach, JD, Executive Director
University Park Plaza
2829 University Ave SE, Suite 500
Minneapolis, MN 55414-3246

Examinee: Tien, Shelly
Alt Name(s): Tien, Shelly Hsiao-Ying

Examinee ID#: 5-158-225-2
Date of Birth: [redacted]1981

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/10/2005	Pass	217	182	88	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/18/2007	Pass	219	182	89	75	

Clinical Skills (CS)*

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/14/2007	Pass					

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
ILLINOIS	08/06/2010	Pass	207	187	86	75	

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

MINNESOTA BOARD OF MEDICAL PRACTICE

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

BOARD

MAR – 5 2012

CERTIFICATION OF MEDICAL EDUCATION

PRAC

This form is for certification of medical education and must be completed and mailed by the facility directly to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name Shelly Tien SS# [redacted]

Signature Shelly Tien Date 2/27/12

Date of Degree 5/2008 Degree Received M.D., MPH

THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT:(Name of Physician) Shelly Tien

MATRICULATED IN:(Name of School) Tufts University School of Medicine

AT:(Location of School) 145 Harrison Ave., Boston, MA 02111

AND RECEIVED A DIPLOMA CONFERRING:(Degree) MD/MPH

ON:(Month, Day, Year) 5/18/08

ANY DISCIPLINARY ACTION? Yes*_____ No ✓
(N/A is not an acceptable response)

ANY DEROGATORY INFORMATION ON FILE? Yes*_____ No ✓
(N/A is not an acceptable response)

School Seal**

President, Secretary, Dean, Registrar:

Print Name Carol A. Duffey

Signature Carol A. Duffey

Date 3/1/12

Phone Number (617) 636-6568

Fax Number (617) 636-0432

*Please attach letter of explanation.

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

01/02

Tufts University

School of Medicine

Be it known that

Shelly Hsiao-Ying Tien

having satisfied in full the requirements for the degree of

Doctor of Medicine

has been admitted to that degree with all
the rights, privileges and honors pertaining thereto.
In witness of this action the seal of the University and the signatures
authorized by the Board of Trustees are affixed below.
Given at Medford, Massachusetts, on the eighteenth day of May
in the year two thousand and eight.

Michael Rosenblatt, M.D.
Dean

SIGILLUM UNIVERSITATIS TUFTENSIS 1852 PAX ET LUX SISIS

Lawrence S. Bacow
President

55482

55-82

MINNESOTA BOARD OF MEDICAL PRACTICE

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

VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

(Copy this form for multiple programs)

This form is for verification of all US/Canadian post graduate medical training (i.e. internship, residency and fellowship) and must be completed and mailed by the facility DIRECTLY to the **Minnesota Board of Medical Practice**. The applicant's signature authorizes release of information, favorable or otherwise, DIRECTLY to the Board.

Print Name Shelly H. Tien SS# [redacted]

Signature Shelly Tien Date 2/27/12

Training Dates (Month,Day,Year) 7/1/2008 - June 30, 2012 Birthdate 7/18/81

This section is to be completed by the Program Director or Graduate Medical Education Representative

It is hereby certified that:(Name of Applicant) Shelly Tien

Received credit for post graduate training:(# Months) 48 from date: 7/1/2008 to date: 6/30/2012

The program was accredited to provide graduate, clinical, medical training during the dates above by: (Check One)
ACGME X AOA ___ RCPSC ___ CFPC ___ None of the above ___ (explain) ___

at:(Name of Hospital or Institution) Advocate Illinois Masonic Medical Center

located at 836 W Wellington Av Chicago, IL 60657
(Street Address, City, State, Zip, Country)

Affiliated Medical School Name Univ of Illinois Specialty OB/GYN PGY 4

Training Program (Check One): Internship ___ Resident X Chief Resident ___ Fellowship ___ Research ___

Did the applicant complete all required years of the post graduate training program?
Program was completed ___ X Anticipated date of completion 6/30/2012

___ Program was not completed because ___

Was this individual issued a certificate as proof completion of training? ..... will be issued Yes X No ___

Did the individual take a leave of absence or break during training? ..... Yes* ___ No X

Was this individual ever placed on probation or remediation? ..... Yes* ___ No X

Was this individual ever disciplined or placed under investigation? ..... Yes* ___ No X

Were any limitations or special requirements placed upon this individual due to academic incompetence, disciplinary problems or any other reason? ..... Yes* ___ No X

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by Program Director or Graduate Medical Education Representative:

Print Name Brenda Darrell

Signature Brenda Darrell MD

Date 2/28/2012 Phone 773 296 5591

Fax 773 296 7207 Email Brenda.Darrell@advocatehealth.com

*Attach letter of explanation

1/2011

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MINNESOTA BOARD OF MEDICAL PRACTICE

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

PHYSICIAN RECOMMENDATION FORM

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 7 of the application. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name Shelly Tien

Signature Shelly Tien Date 2/28/12

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Physician) Shelly Tien

1. How long have you known the applicant? 4 years
2. What has been the nature of your relationship with the applicant? Program director - resident
3. How would you characterize the moral and professional conduct of the applicant? Dr Tien has an excellent moral character and demonstrates excellent professional behavior
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.	Marginal*	(Fully Meets Standards)	A. Clinical skills
B.	Yes*	(No)	B. Any indication of chemical dependency?
C.	Yes*	(No)	C. Any indication of malprescribing?

Completed By:

Print Name Brenda Darrell Phone 773 296 5591

Address 836 W Wellington Av Chicago IL 60657

Signature B Darrell MD Date 2/28/2012

*Please attach letter of explanation.

01/02

55482

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Print Name Shelly Tien

Signature Shelly Tien Date 2/27/12

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Physician) SHELLY TIEN M.D.

1. How long have you known the applicant? 4 yrs.
2. What has been the nature of your relationship with the applicant? I worked with Dr. Tien as her chief resident and am now her attending
3. How would you characterize the moral and professional conduct of the applicant? Excellent moral character. Always professional and upstanding in clinical practice.
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.	Marginal*	(Fully Meets Standards)	A. Clinical skills
B.	Yes*	(No)	B. Any indication of chemical dependency?
C.	Yes*	(No)	C. Any indication of malprescribing?

Completed By:

Print Name DAVID A. ROSAS M.D. Phone 708-717-3332

Address 1005 N. LINCOLN AVE APT 6 CHICAGO IL 60622

Signature David A. Rosas Date 3/1/12.

*Please attach letter of explanation.

01/02

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MALPRACTICE HISTORY REPORT

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

NAME AND ADDRESS OF PROFESSIONAL LIABILITY INSURER IN OTHER STATE:

1. _____
2. _____
3. _____

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

Not applicable – NONE

Number	Date	Disposition

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

Print Name Shelly Tien

Signature Shelly Tien Date 2/28/12

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

01/02