Kansas

EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406[i], please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military/law enforcement agencies.

1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes ☐ No ☑ If yes:

   Branch:_____ Dates of Service:_____ Military ID#:_____

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes☐ No☑ If yes:

   Branch:_____ Dates of Service:_____ Military ID#:_____

3. Do you currently reside in Kansas? Yes☐ No☑ If yes:

   Current Kansas Residence Address:_____

4. If you do not currently reside in Kansas, do you intend* to establish residency in Kansas within the next 6 months? ***If you answer "yes" to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military agencies in other jurisdictions.*** Yes ☐ No ☑ If yes:

   Intended Kansas Residence Address:_____

   Expected Date of Commencing Residence:_____

If you answered "no" to all questions #1 through #4, you do not need to answer questions #5 through #7.

5. Are you currently licensed, registered, or certified to practice (the profession for which you are seeking licensure in Kansas) by another state, district, or territory of the United States and have worked under that license for at least 1 year. ***This does not include certifications or registrations issued by private boards, professional societies, or any organization other than a government body of a state, district, or territory of the U.S.*** Yes☐ No☐ If no:

   a. Have you practiced the profession for which you are seeking licensure in Kansas for at least 3 years in a state that does not license/register/certify the profession? Yes ☐ No☐

   b. Have you practiced the profession for which you are seeking licensure in Kansas for at least 2 years in a state that does not license/register/certify the profession and you held a certification or registration issued by a private organization during those 2 years? Yes☐ No☐ If yes:

      Organization that issued private certification/registration: _____ Date Issued: _____

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Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

Kansas

*** "Active practice" does not include care provided while in a training program, residency, or fellowship; or employment that consisted solely of research activities or administrative duties. The Board generally considers active practice to be direct patient care that for either (1) at least one full day per week for 50 weeks during a year; or (2) 400 hours during a year.**

6. Have you actively practiced* the profession for which you are seeking licensure in Kansas during the last 2 years? Yes☐ No☐

If you answered "yes" to question #6, you do not need to answer question #7.

7. If you answered "No" to questions #6, please provide a detailed explanation regarding your active clinical practice and direct patient care during the 12 months immediately preceding the submission of your application. Please explain any gaps in active practice in the 12 months immediately preceding the submission for your application, including the amount of time and reason.

[i] An applicant who has not been in the active practice of their occupation during the two years preceding the application for which a license is sought, may be required to complete additional testing, training, monitoring or continuing education as the KSBHA deems necessary to establish present ability to practice in a manner that protects the health and safety of the public. K.S.A. 48-3406(d).

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

Uniform Application for Licensure

Application ID: 353124
FID: 215079179

License Requested: MD
License Type: Permanent Medical License
Submitted to: Kansas State Board of Healing Arts
Submission Date: 4/11/2022 7:00 PM

Practitioner Name

Tien, Shelly Hsiao-Ying

Contact Information

Address

Public Access	Board Contact	Type	Address
Yes	Yes	Home	CONFIDENTIAL

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	Yes	Mobile	CONFIDENTIAL	

Email

Public Access	Board Contact	Email
Yes	Yes	CONFIDENTIAL

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
51582252	CONFIDENTIAL		Northampton, Massachusetts UNITED STATES	F	1457500787	MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Tufts University School of Medicine	136 Harrison Avenue Boston, MA 02111 UNITED STATES	07/01/2003	06/30/2008	05/18/2008	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name:	**Advocate Health Care/Advocate Illinois Masonic Medical Center Program** Chicago, IL UNITED STATES	**Program Code:**	ACGME 2201621085
		Attendance Dates:	
Institution:	Advocate Health Care	**Start Date:**	07/01/2008
Training Specialty:	Obstetrics & Gynecology	**End Date:**	06/30/2012
		Program Type:	Residency
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**University of Minnesota Program** Minneapolis, MN UNITED STATES	**Program Code:**	ACGME 2302622002
		Attendance Dates:	
Institution:	University of Minnesota	**Start Date:**	07/01/2012
Training Specialty:	Obstetrics & Gynecology/Maternal-Fetal Medicine	**End Date:**	06/30/2015
		Program Type:	Fellowship
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		06/10/2005	Pass	1
USMLE Step 2 CS Examination		06/14/2007	Pass	1
USMLE Step 2 CK Examination		06/18/2007	Pass	1
USMLE Step 3 Examination		08/06/2010	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Alabama State Board of Medical Examiners	AL	00043189	09/22/2021	12/31/2022	Full	Active
Illinois Department of Financial and Professional Regulation	IL	036128275	06/29/2011	07/31/2023	Full	Active
Illinois Department of Financial and Professional Regulation	IL	125054448	05/21/2008	06/30/2011	Temporary	Canceled
Oklahoma State Board of Medical Licensure & Supervision	OK	37191	11/01/2020	11/01/2022	Full	Active
Minnesota Board of Medical Practice	MN	55482	07/14/2012	07/31/2015	Full	Inactive
Florida Board of Medicine	FL	ME147816	11/12/2020	01/31/2023	Full	Active
Arizona Medical Board	AZ	65210	12/27/2021	11/18/2023		Active

Physician Reported License History

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

Chronology of Activity Type

Practice/Emp/ Desc: **Tufts University School of Medicine**
Chronology Type: Medical Education
Address: Boston, MA US
Attendance Dates:
Position/Dept:
From: 07/01/2003 to 06/30/2008
Clinical %:
Admin %:
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **Advocate Health Care/Advocate Illinois Masonic Medical Center Program**
Chronology Type: Accredited Training
Address: Chicago, IL US
Attendance Dates:
Position/Dept:
From: 07/01/2008 to 06/30/2012
Clinical %: 100
Admin %: 0
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **University of Minnesota Program**
Chronology Type: Accredited Training
Address: Minneapolis, MN US
Attendance Dates:
Position/Dept:
From: 07/01/2012 to 06/30/2015
Clinical %: 100
Admin %: 0
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **Northshore University Health System**
Chronology Type: Work
Address: Evanston Hospital
2650 Ridge Avenue
Evanston, IL 60201
US
Attendance Dates:
Position/Dept: physician - Maternal-Fetal Medicine
From: 07/20/2015 to 12/31/2020
Clinical %: 100
Admin %: 0
Employment: • **Staff Privileges:** • **Affiliation:** ◦

Practice/Emp/ Desc: **vacation**
Chronology Type: Vacation

Address:

Attendance Dates:

Position/Dept:

From: 01/01/2021 to 03/01/2021

Clinical %: 0

Admin %: 0

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

Practice/Emp/ Desc: **Trust Women**

Chronology Type: Work

Address: 1240 SW 44th Street
Oklahoma city, OK 73109
US

Attendance Dates:

Position/Dept: physician - maternal-fetal medicine/family planning

From: 02/18/2021 to In Progress

Clinical %: 100

Admin %: 0

Employment: • **Staff Privileges:** • **Affiliation:** ○

Practice/Emp/ Desc: **Planned Parenthood South, East, North Florida**

Chronology Type: Work

Address: 2300 N Florida Mango Road
West Palm Beach, FL 33409
US

Attendance Dates:

Position/Dept: physician - Maternal-Fetal medicine/Family planning

From: 03/01/2021 to In Progress

Clinical %: 100

Admin %: 0

Employment: • **Staff Privileges:** • **Affiliation:** ○

Malpractice

None Reported

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Uniform Application – Core Application

Applicant: Follow the instructions given in the left sidebar of each page.
Send this application to the Kansas State Board of Healing Arts,
800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

Indicate your full legal name and any other names you have used in the past. 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 to the Board.

Full Name

Last name: Tien Suffix: _____

First name: Shelly

Middle name: Hsiao-Ying

Maiden name (if applicable): _____

All other names used/identified as: _____

_____ Degree Type ☒ M.D. ☐ D.O.

Please complete all fields and indicate which address you want to use for public access and at which address you want to receive mailings from the Board. Addresses may vary on which address or phone number is or is not a matter of public record. Additionally, many state boards publish the Public Access address on their web sites. You may wish to contact the appropriate state licensing authority to determine which information will be a matter of public record.

Practice Address

☒ Public Access

☐ Mailings for Medical Board

Street: 5107 E Kellogg Dr.

Pete Vadra Beach

City: Wichita

State/Province: KS

Zip code: 67218 Country: _____

Practice phone: 316-260-6934 Practice fax: _____

Alternate phone: _____ Alternate fax: _____

Practice email: _____

Home Address

☐ Public Access

☒ Mailings for Medical Board

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If you are not using FCVS, you must submit one of the following to the Board: certified birth certificate, notarized copy of your birth certificate, original valid passport, or notarized copy of your current valid passport. Please check the state specific instructions for more information.

Be sure to list your name at the top of each following page.

Identification

Date of birth: CONFIDENTIAL (mm/dd/yyyy) Gender: F Birth city: Northampton

Birth state/province: MA Birth country: USA

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Social Security number*: _____ (9 digits) NPI number**: 1457500787 (10 digits) U.S. Citizen? ☑ 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, visit http://www.cms.hhs.gov/NationalProvidentStand

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Applicant Name: Shelly Tien

List all medical schools you have attended, even those from which you did not graduate, in chronological order. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Medical Education Verification form and send it to all medical schools you have attended. Include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to the Board.

Additionally, the medical school must provide the Board with an official copy of your transcripts. If transcripts are not in English, an original, certified, and official English translation is required.

If you attended a Fifth Pathway program and are not using FCVS, you must complete the 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 the Board.

If ECFMG is applicable and you are not using FCVS, contact ECFMG and have a certified status report forwarded from them to the Board. There is a separate fee for this report.

Medical School

1. Full Name of Medical School: TUFTS UNIVERSITY SCHOOL OF MEDICINE

Street: 136 HARRISON AVENUE

City: BOSTON State/Province: MA Zip code: 02111

Country: USA Attendance dates: From 8/2003 (mm/yyyy) to 5/2008 (mm/yyyy)

Date degree conferred/issued (indicate if not applicable): 5/18/2008 (mm/dd/yyyy)

Degree received (as stated on diploma): MD/MPH (indicate if not applicable)

2. Full Name of Medical School: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy)

Date degree conferred/issued (indicate if not applicable): _____ (mm/dd/yyyy)

Degree received (as stated on diploma): _____ (indicate if not applicable)

Fifth Pathway

☑ I did not participate in a Fifth Pathway program.

Affiliated medical school that awarded the Fifth Pathway Certification

Full Name of Medical School: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy)

Date degree conferred/issued: _____ (mm/dd/yyyy) Degree (as stated on diploma): _____

Hospital or clinic in which you performed the required rotations

Institution name: _____

Rotation dates: From _____ (mm/yyyy) to _____ (mm/yyyy) Certificate date: _____ (mm/dd/yyyy)

ECFMG

☑ I do not have an ECFMG certificate.

Certificate number: _____ Issue date: _____ (mm/dd/yyyy)

Applicant Name: Shelly Tien

List all postgraduate programs you have attended, even those you did not complete. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the 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 the Board. The postgraduate program must forward all documentation directly to the Board.

Postgraduate Training

1. Full Name of Hospital: ADVOCATE ILLINOIS MASONIC MEDICAL CENTER
Street: 836 WEST WELLINGTON AVENUE
City: CHICAGO State/Province: IL Zip code: 60657
Country: US Department/Specialty: OBSTETRICS AND GYNECOLOGY
Affiliated medical school name:
Attendance dates: From 7/2008 (mm/yyyy) to 6/2012 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): 1,2,3,4

- ☐ Chief Resident
- ☐ Fellowship
- ☐ Fellowship/Research
- ☐ House Officer
- ☐ Internship
- ☑ Internship/Residency
- ☐ Junior Registrar
- ☐ Preliminary
- ☐ Registrar
- ☐ Research
- ☑ Residency
- ☐ Residency/Chief Residency
- ☐ Senior House Officer
- ☐ Senior Registrar
- ☐ Other:
- ☐ Transitional
- ☐ Unknown
- ☐ Unspecified

Successfully completed? ☑ Yes ☐ No ☐ In progress; expected completion in (mm/yyyy)

2. Full Name of Hospital: UNIVERSITY OF MINNESOTA, MINNEAPOLIS
Street: Moos Tower, 12th Floor, 515 Delaware St.
City: MINNEAPOLIS State/Province: MN Zip code: 55455
Country: US Department/Specialty: MATERNAL-FETAL MEDICINE
Affiliated medical school name: UNIVERSITY OF MINNESOTA
Attendance dates: From 7/2012 (mm/yyyy) to 6/2015 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): 5,6,7

- ☐ Chief Resident
- ☑ Fellowship
- ☐ Fellowship/Research
- ☐ House Officer
- ☐ Internship
- ☐ Internship/Residency
- ☐ Junior Registrar
- ☐ Preliminary
- ☐ Registrar
- ☐ Research
- ☐ Residency
- ☐ Residency/Chief Residency
- ☐ Senior House Officer
- ☐ Senior Registrar
- ☐ Other:
- ☐ Transitional
- ☐ Unknown
- ☐ Unspecified

Successfully completed? ☑ Yes ☐ No ☐ In progress; expected completion in (mm/yyyy)

3. Full Name of Hospital:
Street:
City: State/Province: Zip code:
Country: Department/Specialty:
Affiliated medical school name:
Attendance dates: From (mm/yyyy) to (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.):

- ☐ Chief Resident
- ☐ Fellowship
- ☐ Fellowship/Research
- ☐ House Officer
- ☐ Internship
- ☐ Internship/Residency
- ☐ Junior Registrar
- ☐ Preliminary
- ☐ Registrar
- ☐ Research
- ☐ Residency
- ☐ Residency/Chief Residency
- ☐ Senior House Officer
- ☐ Senior Registrar
- ☐ Other:
- ☐ Transitional
- ☐ Unknown
- ☐ Unspecified

Successfully completed? ☐ Yes ☐ No ☐ In progress; expected completion in (mm/yyyy)

Applicant Name: Shelly Tien

List the information for each licensure exam you have taken, whether U.S. or international (USMLE, LLMCC, NBME, etc.).

If you are not using FCVS, you must contact the appropriate examination entity and have them send a certified transcript of your scores directly to the Board.

Examination History

Examination	Most recent date taken (mm/yyyy)	Passed/Failed/Unknown	Number of attempts
FLEX Pre-1985		☐ (P) ☐ (F) ☐ (U)	
FLEX Component 1		☐ (P) ☐ (F) ☐ (U)	
FLEX Component 2		☐ (P) ☐ (F) ☐ (U)	
LMCC – Single		☐ (P) ☐ (F) ☐ (U)	
LMCC – Part I		☐ (P) ☐ (F) ☐ (U)	
LMCC – Part II		☐ (P) ☐ (F) ☐ (U)	
NBME Part I		☐ (P) ☐ (F) ☐ (U)	
NBME Part II		☐ (P) ☐ (F) ☐ (U)	
NBME Part III		☐ (P) ☐ (F) ☐ (U)	
SPEX		☐ (P) ☐ (F) ☐ (U)	
NBOME Part I		☐ (P) ☐ (F) ☐ (U)	
NBOME Part II		☐ (P) ☐ (F) ☐ (U)	
NBOME Part III		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 1		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 2, CE		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 2, PE		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 3		☐ (P) ☐ (F) ☐ (U)	
COMVEX		☐ (P) ☐ (F) ☐ (U)	
USMLE Step I	6/10/2005	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CS	6/14/2007	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CK	6/18/2007	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step III	8/6/2010	☑ (P) ☐ (F) ☐ (U)	1
State Board Exam			
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	

List all state and Canadian provinces where you currently hold or have ever held any type of health care related license. Please copy and attach additional pages if necessary.

You must also complete the Licensure Verification form and send it to all states in which you have held any health care license or certification. Some state boards charge a fee for this information. The verifying entity must forward all licensure documentation to the Board.

State/Province Professional Licensure ☐

1. Practitioner license type: ☑ Full license ☐ Temporary ☐ Training ☐ Limited

- ■ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: FLORIDA License number: ME147815 Issue date: 11/13/2020

License status: ■ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

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Applicant Name: Shelly Tien

Please copy and attach additional pages if necessary.

2. Practitioner license type: ☑ Full license ☐ Temporary ☐ Training ☐ Limited

- ■ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: OKLAHOMA License number: 37191 Issue date: 11/2/21

License status: ■ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

3. Practitioner license type: ☑ Full license ☐ Temporary ☐ Training ☐ Limited

- ■ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: ALABAMA License number: MD43189 Issue date: 9/22/21

License status: ■ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

4. Practitioner license type: ☑ Full license ☐ Temporary ☐ Training ☐ Limited

- ■ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: ARIZONA License number: 65210 Issue date: 12/27/21

License status: ■ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

5. Practitioner license type: ☑ Full license ☐ Temporary ☐ Training ☐ Limited

- ■ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: ILLLINOIS License number: 036128275 Issue date: 6/29/2011

License status: ■ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

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Applicant Name: Shelly Tien

List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, indicating month and year.

*Also list your permanent or home address for each non-working time.

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 SECTION.

Copy and attach additional pages as necessary.

** Clinical indicates the percentage of time spent with patients.

*** Administrative indicates the percentage of time spent on administrative tasks like paperwork, etc.

Chronology of Activities

1. Start date: 7/1/2008 (mm/yyyy) End date: 6/30/2012 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☒ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: Obstetrics and Gynecology residency training at Advocate Illinois Masonic Medical Center

Street: 836 West Wellington Avenue

City: Chicago State/Province: IL Zip code: 60657

Country: USA Position: obgyn resident

Department: obstetrics and gynecology Clinical**: 100 % Administrative***: ___ %

☒ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

2. Start date: 7/1/2012 (mm/yyyy) End date: 6/30/2015 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☒ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: Maternal-fetal medicine fellowship subspecialty training at the University of Minnesota

Street: Moos Tower, 12th Floor 515 Delaware St.

City: Minneapolis State/Province: MN Zip code: 55455

Country: USA Position: maternal-fetal medicine fellow

Department: maternal-fetal medicine Clinical**: 100 % Administrative***: ___ %

☒ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

3. Start date: 7/20/2015 (mm/yyyy) End date: 12/31/2020 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name or Description of non-working time*: Physician at Northshore/U of Chicago

Street: 2650 Ridge Avenue

City: Evanston State/Province: IL Zip code: 60201

Country: USA Position: physician

Department: maternal-fetal medicine Clinical**: 100 % Administrative***: ___ %

☒ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

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Applicant Name: Shelly Tien

Copy and attach additional pages as necessary.

4. Start date: 3/1/2021 (mm/yyyy) End date: current (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name or Description of non-working time*: Physician at PP South, East North Florida

Street: 5978 Powers Avenue

City: Jacksonville State/Province: FL Zip code: 32217

Country: USA Position: physician

Department: maternal-fetal medicine, family planning Clinical**: 100 % Administrative***: ____%

☒ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

5. Start date: 2/2021 (mm/yyyy) End date: current (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name or Description of non-working time*: Physician at Trust Women

Street: 1240 SW 44th Street

City: Oklahoma city State/Province: OK Zip code: 73109

Country: USA Position: physician

Department: women's health and gynecology Clinical**: 100 % Administrative***: ____%

☒ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

6. Start date: 1/2021 (mm/yyyy) End date: 2/2021 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☒ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: moving and vacation

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

Please copy and attach additional pages as necessary.

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KSBHA

Applicant Name: Shelly Tien

You must complete this section to report 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 private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

☑ I have not had any malpractice claims or suits made against me.

1. Name of patient involved: _____

In which state, territory, or province did the action take place? _____

Which court*? _____

Case number (if applicable) _____ Month and year of lawsuit: _____

Month and year of event precipitating claim: _____

Current claim status: ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Open (pending) ☐ Other: _____

Amount of judgment or settlement: $_____ Amount paid on your behalf: $_____

What is/was your status? ☐ Primary Defendant ☐ Co-Defendant ☐ Other (specify): _____

Insurance carrier at the time: _____

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

Complete the forms on the following pages as instructed.

☐ UA Affidavit and Authorization for Release of Information
☐ UA Form #1: Licensure Verification Form
☐ All state-specific forms included with this core application

If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

☐ UA Form #2: Medical School Verification
☐ UA Form #3: Postgraduate Training Verification
☐ UA Form #4: Fifth Pathway Verification (if applicable)

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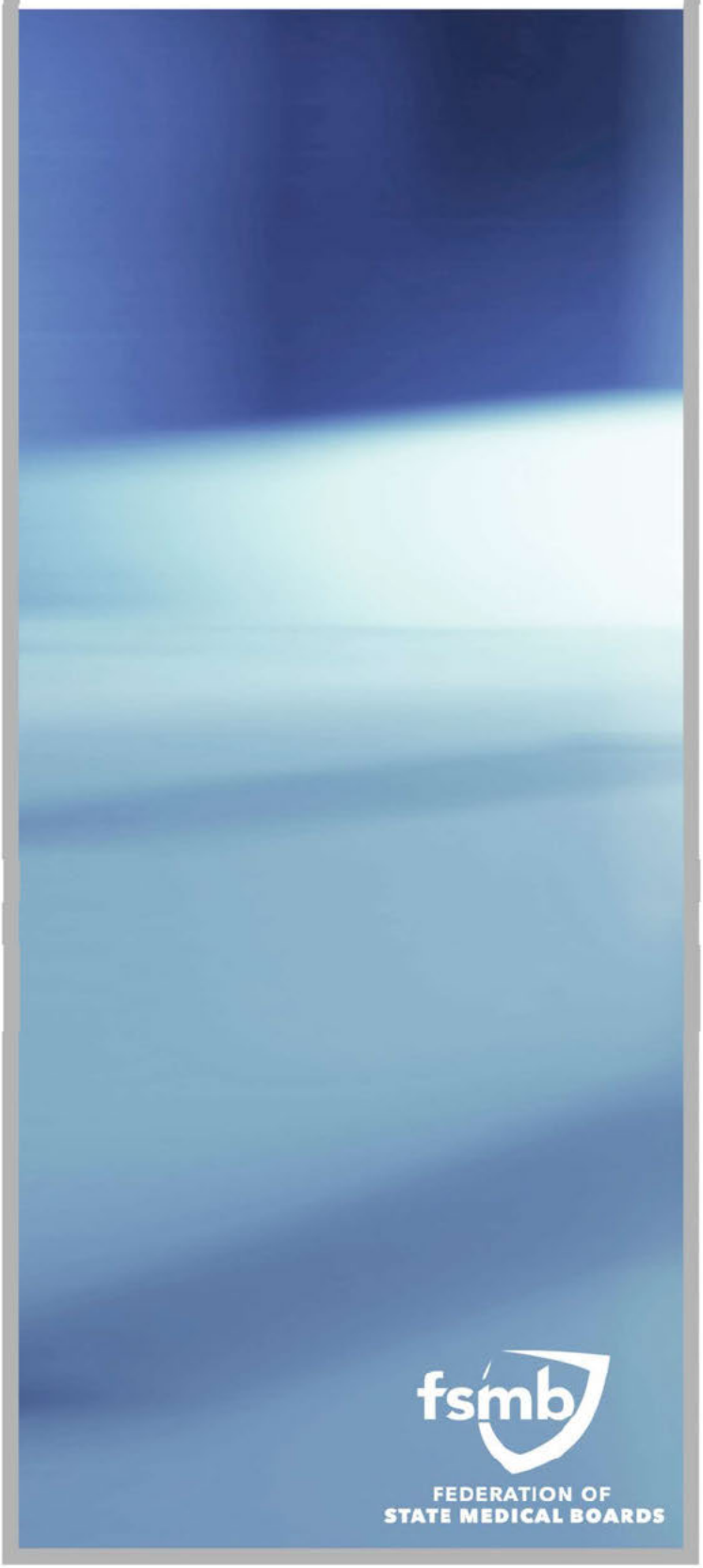
APR 21 2022

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE



Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Tien, Shelly Hsiao-Ying**
Social Security Number:	CONFIDENTIAL
Date of Birth:	
FID#:	**215079179**
Recipient:	**KS - Kansas State Board of Healing Arts**
Delivery Date:	**06/08/2022**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

fsmb

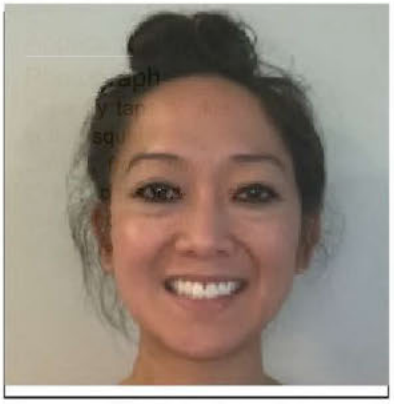
I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect 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 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 me 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 Federation Credentials Verification Service 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 Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.



Shelly Tien
Applicant's Signature (must be signed in the presence of a notary)

Tien
Applicant's Printed Last Name

Shelly H
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

05/05/2022
Date of Signature (must correspond to date of notarization)

Commonwealth of Pennsylvania - Notary Seal
ELAINE L. JOHNSON - Notary Public
Bucks County
My Commission Expires January 8, 2023
Commission Number 1287755

State of Pennsylvania, County of Bucks

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 05 day of May, 2022.

Notary Public Signature: Elaine L. Johnson

My Notary Commission Expires: 01/08/2023

[X] This notarial act involved the use of communication technology.

Please complete and mail this original document to the Federation of State Medical Boards at:

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL(817)868-5000

FCVS ID Number

FID Number

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

fsmb

Biographic Information

Medical professional Name(s): **Tien, Shelly Hsiao-Ying**

Date of Birth: CONFIDENTIAL

Place of Birth: Northampton, Massachusetts, UNITED STATES

Contact Information

Home Address: CONFIDENTIAL

Mobile Phone:

Email:

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Tien (Last) Shelly (First) Hsiao-Ying (Middle)

FCVS ID Number: 215079179

Notary – Please complete the section below:

State of Pennsylvania County of Bucks

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 05, of (Month) May, (Year) 2022.

Notary Public Signature: Elaine L. Johnson

Commission Expiration Date* (Month) 01 /(Day) 08 /(Year) 2023

[X] This notarial act involved the use of communication technology.

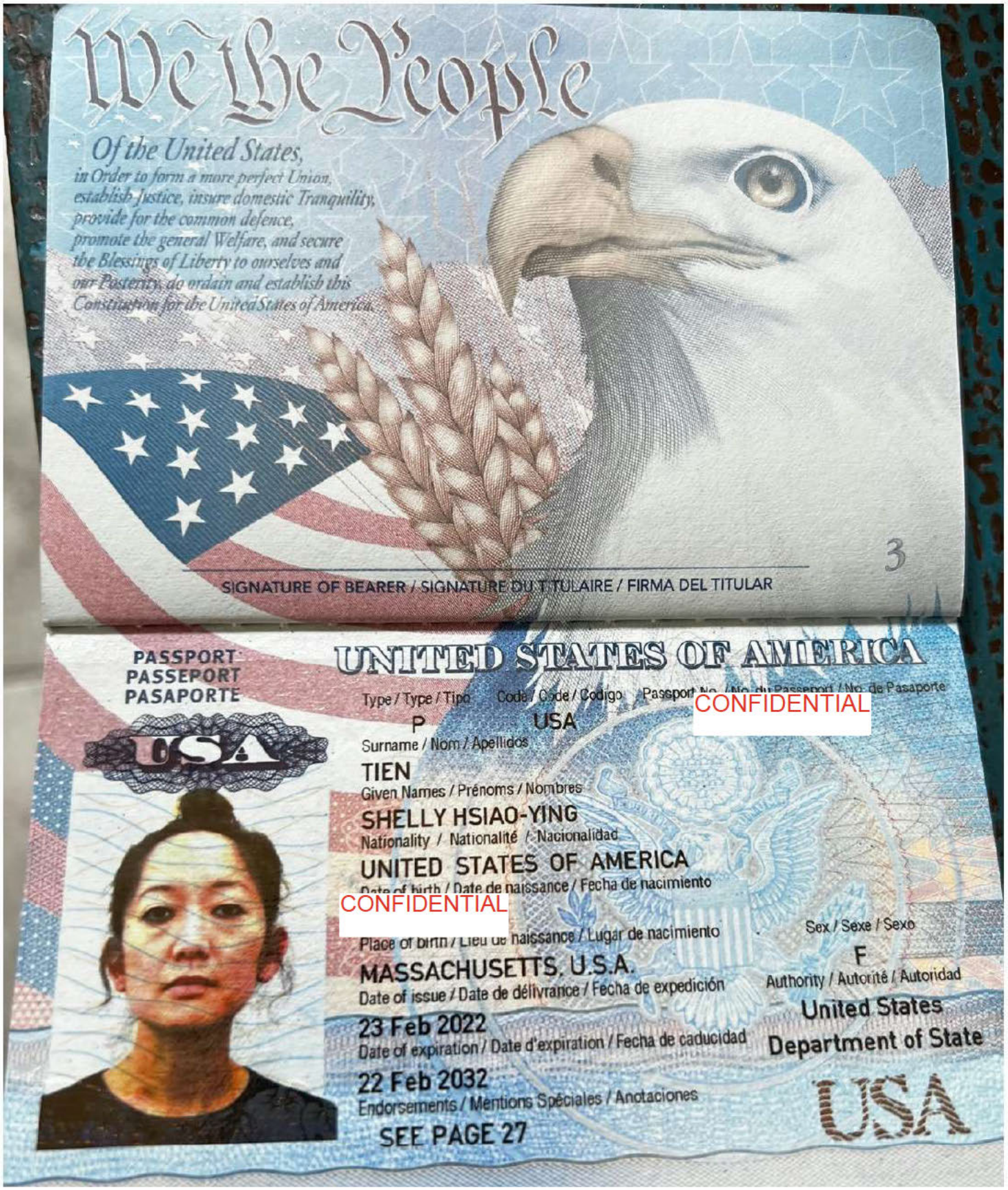
*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Notary Stamp Here

Commonwealth of Pennsylvania - Notary Seal
ELAINE L. JOHNSON - Notary Public
Bucks County
My Commission Expires January 8, 2023
Commission Number 1287755

Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856



FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
07/01/2003	06/30/2008	Medical Education	Tufts University School of Medicine Boston Massachusetts UNITED STATES
07/01/2008	06/30/2012	Postgraduate Training	Advocate Health Care/Advocate Illinois Masonic Medical Center Program Chicago Illinois UNITED STATES
07/01/2012	06/30/2015	Postgraduate Training	University of Minnesota Program Minneapolis Minnesota UNITED STATES
07/20/2015	12/31/2020	Work	Northshore University Health System Evanston Hospital 2650 Ridge Avenue Evanston, Illinois UNITED STATES
01/01/2021	02/17/2021	Vacation	vacation
02/18/2021		Work	Trust Women 1240 SW 44th Street Oklahoma city, Oklahoma UNITED STATES
03/01/2021		Work	Planned Parenthood South, East, North Florida 2300 N Florida Mango Road West Palm Beach, Florida UNITED STATES

End of Chronology of Activities report for: Tien, Shelly Hsiao-Ying

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **Tufts University School of Medicine**

Location: Boston, MA

UNITED STATES

Credentials Analysis Information for Medical Education

Issue:
FCVS has identified a Medical Education Discrepancy at Tufts University School of Medicine.

Attendance Dates

Solution:
FCVS does not follow up when the Verification of Medical Education Form matches the information reported on the Certified Transcript.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Institution Name: Tufts University School of Medicine

City: Boston **State/Province:** Massachusetts **Country:** UNITED STATES

Premedical Education:

Years of education required for admission to your medical school: 3

Credential/degree presented by the applicant for admission to your medical school: Baccalaureate

Enrollment and Participation:

Our records indicate that Tien, Shelly Hsiao-Ying

attended our medical school for a total of 156 weeks of medical education on the following dates: From MM/DD/YYYY: 08/25/2003 To MM/DD/YYYY: 04/18/2008

This individual was awarded the degree of Doctor of Medicine/MPH on 05/18/2008

DS CAD

Unusual circumstances

1. Do this individual's official records reflect (an) interruption(s) in his/her medical education? **YES** X **NO** **N/A**

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

				From MM/DD/YYYY:	To MM/DD/YYYY:	
Personal/Family	Applicable X	N/A		01 / 20 / 2006	07 / 03 / 2006	Approved
Academic remediation	Applicable	N/A X		/ /	/ /	
Health	Applicable	N/A X		/ /	/ /	
Financial	Applicable	N/A X		/ /	/ /	
Participation in joint degree program (e.g., MD/PhD)	Applicable	N/A X		/ /	/ /	
Other	Applicable	N/A X		/ /	/ /	

Other Explanation:

Medical School Code: 022040 FID: 215079179

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? **YES** **NO** X **N/A**

If YES, please select the reason(s) for the probation and indicate the date(s) of placement on and removal from probation.

			From MM/DD/YYYY:	To MM/DD/YYYY:
Academic Probation	Applicable	N/A	/ /	/ /
Probation for unprofessional conduct/behavior	Applicable	N/A	/ /	/ /
Probation for other reason	Applicable	N/A	/ /	/ /

Other Reason Explanation:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? **YES** **NO** X **N/A**

If YES, please provide detailed information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? **YES** **NO** X **N/A**

If YES, please provide detailed information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **YES** **NO** X **N/A**

If YES, please provide detailed information about the nature of the limitations or special requirements:

6. Attach Transcript **7. Attach Diploma** **8. Do you have a Dean's Letter to Attach?** **YES** **NO** X **9. Would you like to upload an additional attachment?** **YES** **NO** X

Attestation of Person completing Verification of Medical Education document: I hereby attest that the information contained herein accurately reflects the training records of the above-named physician.

ELECTRONIC SEAL VERIFIED

Name: Carol A. Duffey

Title: Asst. Dean/Registrar

Signature: DocuSigned by: Carol A. Duffey 84F74577E6364E8...

Date of Signature: 5/6/2022

Email: medical_registrar@tufts.edu

Medical School Code: 022040

FID: 215079179

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Medical School

Medical Professional Name: Tien, Shelly Hsiao-Ying

Tufts University School of Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**Yes**
Dates: 12/2006 To 06/2006	
took additional time and also obtained a Master's in Public Health	
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Tien, Shelly Hsiao-Ying

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

CONFIDENTIAL

CONFIDENTIAL

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.

rd, Massachusetts, on the eighteenth day of May
in the year two thousand and eight.

Carol A Duffey

Certified as a true copy of the original.
Carol A. Duffey, Asst. Dean/Registrar

Michael Rosenblatt, M.D.
Dean

SIGILLUM UNIVERSITATIS TUFTENSIS 1852 PAX ET LUX

Lawrence S. Bacow
President

ELECTRONIC SEAL VERIFIED

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: **2201621085**

Institution: **Advocate Health Care/Advocate Illinois Masonic Medical Center Program**

Location: Chicago, IL
UNITED STATES

Accreditation ID: **2302622002**

Institution: **University of Minnesota Program**

Location: Minneapolis, MN
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Verification of Postgraduate Medical Education

Accreditation Code: 2201621085

Institution Name: Advocate Health Care/Advocate Illinois Masonic Medical Center Program

Affiliated University: Advocate Health Care

City: Chicago **State:** Illinois **Country:** United States

Verification For: Shelly Hsiao-Ying Tien **Date of Birth:** CONFIDENTIAL

Program Participation:

PGY: 1	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 07/01/2008	To: 06/30/2009	Program Type: Residency

PGY: 2	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 07/01/2009	To: 06/30/2010	Program Type: Residency

PGY: 3	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 07/01/2010	To: 06/30/2011	Program Type: Residency

PGY: 5	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 07/01/2011	To: 06/30/2012	Program Type: Residency

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

FID: 215079179

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

To report additional training, include training as an attachment at the end of page 2.

Unusual Circumstances

1. Did this individual ever take a leave of absence from his/her training?	Yes	No x	Not Available
2. Was this individual ever placed on probation?	Yes	No x	Not Available
3. Was this individual ever disciplined or placed under investigation?	Yes	No x	Not Available
4. Were any negative reports for behavioral reasons ever filed by instructors?	Yes	No x	Not Available
5. Were any limitations or special requirements placed upon this individual because of academic incompetence, disciplinary problems, or any other reason?	Yes	No x	Not Available

Attestation of Person completing Verification of Postgraduate Training document (Program Director): I hereby attest that the information contained herein accurately reflects the training records of the above-named physician.

ELECTRONIC SEAL VERIFIED	Name: Charlotte Hammond-Brown Title: Residency Program Administrator Degree: None Signature: DocuSigned by: Charlotte Hammond-Brown 4E770951795F40B... Date of Signature: 5/16/2022

Would you like to upload an additional attachment (e.g. Rotation Schedule)? Yes No x
If reporting additional years in the attachment, include PGY year, specialty, start date, end date, status and program type.

FID: 215079179

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Tien, Shelly Hsiao-Ying
Accreditation ID:	2201621085
Institution:	Advocate Health Care/Advocate Illinois Masonic Medical Center Program
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/2008 - 6/30/2012 **Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Tien, Shelly Hsiao-Ying

Advocate Illinois Masonic Medical Center

Chicago, Illinois

This Certifies that

Shelly H. Tien, M.D.

has faithfully and satisfactorily performed all duties as

Resident in Obstetrics & Gynecology

in this Hospital from July 1, 2008 to June 30, 2012

SEAL

In Witness Whereof *We have hereunto subscribed our names and affixed the seal of the Hospital this 30th day of June 2012*

Program Director

Department Chair

Designated Institutional Officer

Advocate
Illinois Masonic Medical Center
Inspiring medicine. Changing lives.

Vice President for Medical Management

President, Medical Staff

President

Major Affiliate of the University of Illinois College of Medicine

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Verification of Postgraduate Medical Education

Accreditation Code: 2302622002

Institution Name: University of Minnesota Program

Affiliated University: University of Minnesota

City: Minneapolis **State:** Minnesota **Country:** United States

CONFIDENTIAL

Verification For: Shelly Hsiao-Ying Tien **Date of Birth:**

Program Participation:

PGY: 5	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology/Maternal-Fetal Medicine		
From: 07/01/2012	To: 06/30/2013	Program Type: Fellowship

PGY: 6	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology/Maternal-Fetal Medicine		
From: 07/01/2013	To: 06/30/2014	Program Type: Fellowship

PGY: 7	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology/Maternal-Fetal Medicine		
From: 07/01/2014	To: 06/30/2015	Program Type: Fellowship

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

FID: 215079179

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

To report additional training, include training as an attachment at the end of page 2.

Unusual Circumstances

1. Did this individual ever take a leave of absence from his/her training?	Yes	No x	Not Available
2. Was this individual ever placed on probation?	Yes	No x	Not Available
3. Was this individual ever disciplined or placed under investigation?	Yes	No x	Not Available
4. Were any negative reports for behavioral reasons ever filed by instructors?	Yes	No x	Not Available
5. Were any limitations or special requirements placed upon this individual because of academic incompetence, disciplinary problems, or any other reason?	Yes	No x	Not Available

Attestation of Person completing Verification of Postgraduate Training document (Program Director): I hereby attest that the information contained herein accurately reflects the training records of the above-named physician.

ELECTRONIC SEAL VERIFIED	Name: Deborah Egger-Smith Title: Education Manager Degree: None Signature: DocuSigned by: Deborah Egger-Smith 4659FE08ABE5481... Date of Signature: 5/9/2022

Would you like to upload an additional attachment (e.g. Rotation Schedule)? Yes No x
If reporting additional years in the attachment, include PGY year, specialty, start date, end date, status and program type.

FID: 215079179

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Tien, Shelly Hsiao-Ying
Accreditation ID:	2302622002
Institution:	University of Minnesota Program
Specialty:	Obstetrics & Gynecology/Maternal-Fetal Medicine

Unusual Circumstances

Training Period: 7/1/2012 - 6/30/2015 **Fellowship**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Tien, Shelly Hsiao-Ying

University of Minnesota

This certifies that

Shelly H. Tien, M.D., M.P.H.

Has successfully completed and met all the requirements of the

Maternal-Fetal Medicine Fellowship

At the University of Minnesota

Department of Obstetrics, Gynecology and Women's Health

From July 1, 2012 to June 30, 2015

In witness whereof, we have hereunto subscribed our names and affixed the seal of the University of Minnesota this 12th day of June, 2015

Linda F. Carson, M.D.
Professor and Chair

REGENTS OF THE UNIVERSITY OF MINNESOTA

Kirk Ramin, M. D.
Professor and Program Director

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

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

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Date: 06/08/2022

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 713735

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

Examinee ID: 5-158-225-2
Date of Birth: CONFIDENTIAL

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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/10/2005	Pass	CONFIDENTIAL		

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Comments
06/18/2007	Pass	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
06/14/2007	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Comments
08/06/2010	Pass	

End of Exam History

NOTE: The USMLE Step 2 CS examination was last administered March 16, 2020. Examinees with a failing outcome may not have had an opportunity to retest. The USMLE defines successful completion of its examination sequence as passing Step 1, Step 2 CK, and Step 3.

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

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

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Examinee: Tien, Shelly Hsiao-Ying

Examinee ID: 5-158-225-2
Date of Birth: 0CONFIDENTIAL

INTERPRETATION OF RESULTS
USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 1 AND STEP 2 CLINICAL SKILLS (CS)
Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score. All Step 2 CS results are reported as pass or fail, with no numeric score. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale.

ANNOTATIONS APPEARING UNDER"COMMENTS"
Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS"NOTE"
Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS"NOTE"
The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS SMB Profiles	As of Date:6/8/2022

PRACTITIONER INFORMATION

Name:	Tien, Shelly Hsiao-Ying
DOB:	CONFIDENTIAL
Medical School:	Tufts University School of Medicine Boston, Massachusetts, UNITED STATES
Year of Grad:	2008
Degree Type:	MD
NPI:	1457500787

BOARD ACTIONS

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

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1457500787	Individual			11/06/2020

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: FCVS SMB Profiles As of Date:6/8/2022

Practitioner Name: Tien, Shelly Hsiao-Ying

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ALABAMA	00043189	09/22/2021	12/31/2022	05/20/2022
		FSMB License Status: Active		
ARIZONA	65210	12/27/2021	11/18/2023	05/24/2022
		FSMB License Status: Active		
FLORIDA	ME147816	11/12/2020	01/31/2023	05/16/2022
		FSMB License Status: Active		
ILLINOIS	125054448	05/21/2008	06/30/2011	05/27/2022
		FSMB License Status: Canceled		
ILLINOIS	036128275	06/29/2011	07/31/2023	05/27/2022
		FSMB License Status: Active		
MINNESOTA	55482	07/14/2012	07/31/2015	05/24/2022
		FSMB License Status: Inactive		
OKLAHOMA	37191	11/01/2020	11/01/2022	06/03/2022
		FSMB License Status: Active		

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
FT0907189	22N 33N 4 5	BIRMINGHAM,AL 35203	11/30/2024	01/05/2022
FT3187843	22N 33N 4 5	WEST PALM BEACH,FL 33409	11/30/2023	01/05/2022

PRACTITIONER PROFILE

Prepared for: FCVS SMB Profiles As of Date:6/8/2022

Practitioner Name: Tien, Shelly Hsiao-Ying

ABMS® CERTIFICATION HISTORY

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

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2021	12/31/2022		Recertification	05/26/2022
Expired	Time Limited	12/31/2020	12/31/2021		Recertification	05/26/2022
Expired	Time Limited	12/31/2019	12/31/2020		Recertification	05/26/2022
Expired	Time Limited	04/13/2018	12/31/2019		Recertification	05/26/2022
Expired	Time Limited	12/31/2018	12/31/2019		Recertification	05/26/2022
Expired	Time Limited	12/31/2017	12/31/2018		Recertification	05/26/2022
Expired	Time Limited	12/31/2016	12/31/2017		Recertification	05/26/2022
Expired	Time Limited	12/31/2015	12/31/2016		Recertification	05/26/2022
Expired	Time Limited	12/31/2014	12/31/2015		Recertification	05/26/2022
Expired	Time Limited	12/06/2013	12/31/2014		Initial	05/26/2022

Certifying Board: American Board of Obstetrics and Gynecology
Certificate: Maternal-Fetal Medicine
Certification Type: Subspecialty
Certification Status: Certified
Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2021	12/31/2022		Recertification	05/26/2022
Expired	Time Limited	12/31/2020	12/31/2021		Recertification	05/26/2022
Expired	Time Limited	12/31/2019	12/31/2020		Recertification	05/26/2022
Expired	Time Limited	04/13/2018	12/31/2019		Initial	05/26/2022

PRACTITIONER PROFILE

Prepared for:	FCVS SMB Profiles	As of Date:6/8/2022
Practitioner Name:	Tien, Shelly Hsiao-Ying	

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

NPDB Report

TIEN, SHELLY HSIAO-YI **DCN: 5500000191527112**

FOR AUTHORIZED USE BY: Kansas State Board of Healing Arts **Continuous Query ID: 300000012990553**

Process Date: 6/8/2022

The following is a render of data received by National Practitioner Data Bank (NPDB) as interpreted by FSMB

TIEN, SHELLY HSIAO-YI - CONTINUOUS QUERY RESPONSE

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

Practitioner Name:	TIEN, SHELLY HSIAO-YI
Date of Birth:	CONFIDENTIAL
Gender:	FEMALE
Work Address:	711 W GORDON TER APT 301 CHICAGO, IL 60613
Home Address:	CONFIDENTIAL
Social Security Numbers (SSN):	
National Provider Identifiers (NPI):	1457500787
Drug Enforcement Administration (DEA) Numbers:	FT0907189 FT3187843
License(s):	Physician (MD), 00043189, AL Physician (MD), 036128275, IL Physician (MD), 125054448, IL Physician (MD), 37191, OK Physician (MD), 55482, MN Physician (MD), 65210, AZ Physician (MD), ME147816, FL
Professional School(s):	TUFTS UNIVERSITY SCHOOL OF MEDICINE (2008)
Subject ID:	215079179

B. CONTINUOUS QUERY ENROLLMENT INFORMATION

Enrollment Status:	Enrolled - 6/8/2022 - 6/30/2023* * Unless enrollment is canceled by the entity prior to this date
Statutes Queried:	Title IV, Section 1921, Section 1128E
Entity Name:	Kansas State Board of Healing Arts
Authorized Agent:	Federation of State Medical Boards, (817) 868 - 4000
Customer Use:	215079179

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 6/8/2022

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

NPDB Report

TIEN, SHELLY HSIAO-YI **DCN: 5500000191527112**

FOR AUTHORIZED USE BY: Kansas State Board of Healing Arts **Continuous Query ID: 300000012990553**

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure or Certification Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Kansas

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant: In the presence of a notary public, sign and date this form with attached photo. Email completed form to KSBHA_Licensing@ks.gov or mail directly to the Kansas State Board of Healing Arts.

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.

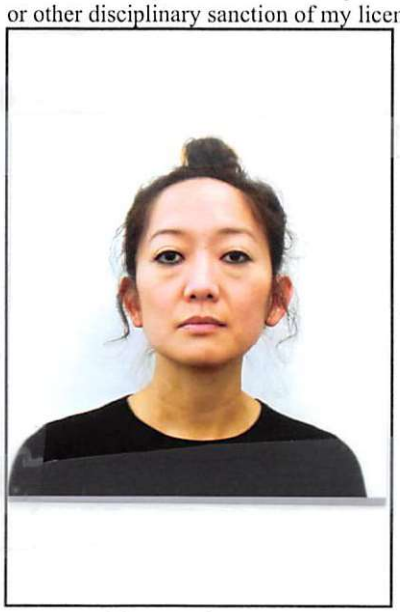
I acknowledge that I have read and understand the application for Medicine and Surgery licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted 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 a change occurs any time prior to a license to practice Medicine and Surgery 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 to practice Medicine and Surgery.



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

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

4/14/22
Date of signature (must correspond to date of notarization)

NOTARY

KHADISHA A. MADISON
Commission # HH 034248
Expires August 19, 2024
Bonded Thru Budget Notary Services

Seal Verified KSBHA

State of Florida, County of Duval,

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 14 day of April, 2022

Notary Public Signature K Madisha A Jackson My Notary Commission Expires 8/19/2024

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

Select the discipline applying for and the license designation being requested.

☑ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

☑ Active

A license issued to a person authorizing the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Applicants for active licensure must provide evidence of professional liability insurance (which will be in effect as of the date of licensure) in compliance with Kansas law before a license will be issued. Each active license may be renewed annually. Licensees must maintain and submit evidence of satisfactory completion of a program of continuing education. Licensees must maintain and submit evidence of professional liability insurance, and contribute to the Kansas Health Care Stabilization Fund (more information about this fund can be found here: https://hcsf.kansas.gov/).

☐ Federal Active

A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

☐ Inactive

A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

☐ Exempt

A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

List intended professional activities: _____

Additional Information:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☑ Yes ☐ No
2. Give location of intended practice in Kansas 5107 E Kellogg Dr., Wichita, KS 67218
3. Primary Specialty obstetrics and gynecology

   American Board Certified 12/6/2013 American Board Eligible _____

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Kansas

ATTESTATION QUESTIONS

Please answer each of the following questions. **All "yes" answers MUST be thoroughly explained in detail on a separate signed page.** You are required to furnish complete details including date, place, reason, and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. **It is imperative you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

If you are unsure of your response to a question, check the "yes" box and submit the appropriate documentation. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty. Please be advised that a false response to any of these questions may be grounds for denial of licensure. If a question is not applicable, then check the "no" box.

Shelly Tien
Full Name of Applicant

4/14/22
Date

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training? Yes ☐ No ☑

2. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes ☐ No ☑

3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? Yes ☐ No ☑

CONFIDENTIAL

4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?

5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?

7. Have you ever voluntarily surrendered any professional license? Yes ☐ No ☑

8. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held? Yes ☐ No ☑

9. Have you ever been notified or requested to appear before a licensing or disciplinary agency? Yes ☐ No ☑

10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility? Yes ☐ No ☑

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Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

Kansas

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11. Has any professional association imposed any disciplinary action against you? Yes ☐ No ☑
12. Do you have any physical or mental health condition (including alcohol or substance use) that currently impairs your ability to practice your profession in a competent, ethical, and professional manner?
13. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances? Yes ☐ No ☑
14. Have you ever surrendered your state or federal controlled substances registration, or had it revoked, suspended, or restricted in any way? Yes ☐ No ☑
15. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency? Yes ☐ No ☑
16. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes ☐ No ☑
17. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes ☐ No ☑
18. Have you ever been court martialed or discharged dishonorably from the armed services? Yes ☐ No ☑
19. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself? Yes ☐ No ☑
20. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company? Yes ☐ No ☑
21. Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company? Yes ☐ No ☑

It is your continued duty to update the Board on any changes once the application has been submitted.

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Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

The FBI will forward your challenge to the appropriate contributing agency to verify or correct the entry. Upon receipt of an official communication directly from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (see 28 CFR 16.30 through 16.34). The Authorized Recipient must submit a new set of fingerprints and fee to receive the updated federal criminal history record.

I have ☐ ***OR*** have not ☑ been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under the provisions of Title 21 Kansas Statutes Annotated, Section 5903.

The name, address, and date of birth provided below appear on a valid identification document as defined in Title 28 United States Code, section 1028.

I have been provided the Waiver Agreement, FBI Privacy Act Statement, and information how to challenge my criminal records for accuracy and completeness.

Shelly Tien — 4/11/22
Signature — Date

CONFIDENTIAL

Shelly H. Tien

CONFIDENTIAL

Residential Address — City — State — Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

Method of Verifying Identity: ☒ Driver's License ☐ State Issued ID Card ☐ Military ID Card

State/Branch: FL DMV ID Number: CONFIDENTIAL

Agency Name: ACES

Address: 10365 HOOD RD S STE 103 JAX FL 32257

Telephone: (904) 482-3305 Fax:

Name of Individual Verifying Identity: RACHEL JACKSON

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AUTHORIZED RECIPIENT: *1. Must maintain original or arrange for KBI to maintain.*
2. Must provide a copy to the applicant.

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AMA Physician Profile

PREPARED FOR

Kansas State Board of Healing Arts, Topeka, KS

Name and Mailing Address

SHELLY HSIAO-YING TIEN
STE 1420
2650 RIDGE AVE
EVANSTON, IL 60201-1700

Birth date CONFIDENTIAL

Primary Office Address

SAME AS MAILING ADDRESS

Phone (847) 570-2860

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)
UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source.

Current and/or historical National Provider Identifier (NPI) information

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1457500787	09/10/2008	NOT RPTD	NOT RPTD	NOT RPTD	04/22/2022

Current and/or historical medical school

US medical school information is verified directly from the school. In some instances, a medical school will designate the National Student Clearinghouse (NSC) as its verification agent. Instances of verification by NSC are indicated on an AMA Profile when applicable.

*On the profile, **enrollment date** is understood to mean the date a student begins a pre-matriculation program, attends orientation immediately preceding enrollment, or becomes enrolled in classes at a medical school. **Degree date** is understood to mean the date a physician is awarded his/her degree upon completion of the degree program. When provided by the primary source, a month is also included for these two dates. Date information provided by primary sources does vary. Enrollment date for international medical graduates is not reported to AMA.*

School: TUFTS UNIVERSITY SCHOOL OF MEDICINE

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	08/2003	**Degree Date:**	05/2008

Current and/or historical ACGME-accredited graduate medical training programs

This section's data is sourced only from training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) as part of the National Graduate Medical Education Census. Program name is only reported for training received in 2010 and later. Training types are identified as specialty (residency) or subspecialty (fellowship) only for training received in 2016 and later.

The AMA Profile does not include non-ACGME accredited training programs, and the absence of such does not necessarily indicate a gap in training.

Training performed in Canada or at an accredited US osteopathic institution is updated only upon verification by the program. US licensing authorities accept GME from both entities as equivalent to training performed at an ACGME-accredited program.

*Verification of training status may be indicated in one of four ways. **Completed** indicates that the training has been completed in its entirety and verified with the program. **Training in Progress** indicates the training has a future completion date and is verified as in progress. **Verification of Completion in Progress** indicates the training has a past completion date and was verified as in progress but the program has not yet verified completion. **Partially Completed** indicates the training is verified as partially completed but the physician either changed programs or did not complete the training.*

Sponsoring Institution:	ADVOCATE ILLINOIS MASONIC MEDICAL CENTER
Sponsoring State:	ILLINOIS
Specialty:	OBSTETRICS & GYNECOLOGY
Training Type:	
Dates:	07/2008 - 06/2012
Status:	COMPLETED

Specialty board certification

This section provides specialty board certification data specific to one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the 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: MATERNAL-FETAL MEDICINE
Certificate type: SUB-SPECIALTY

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
TIME LIMITED	Active	12/31/2021	12/31/2022		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2020	12/31/2021		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2019	12/31/2020		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	04/13/2018	12/31/2019		INITIAL	04/26/2022	Y

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

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
TIME LIMITED	Active	12/31/2021	12/31/2022		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2020	12/31/2021		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2019	12/31/2020		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2018	12/31/2019		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	04/13/2018	12/31/2019		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2017	12/31/2018		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2016	12/31/2017		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2015	12/31/2016		RE-CERT	04/26/2022	Y

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
TIME LIMITED	Expired	12/31/2014	12/31/2015		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/06/2013	12/31/2014		INITIAL	04/26/2022	Y

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.

Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
036.128275	MD	IL	06/29/2011	07/31/2023		ACT	UNL	12/31/2021	SHELLY TIEN
147816	MD	FL	11/12/2020	01/31/2023		ACT	UNL	02/08/2022	Shelly Tien
55482	MD	MN	07/14/2012	07/31/2015		INA	UNL	02/03/2022	Shelly Hsiao-Ying Tien
125.054448	MD	IL	05/21/2008	06/30/2011		INA	RES	12/31/2021	SHELLY TIEN

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

Action notifications reported to the AMA

Medical Licensing Boards: NO ACTIONS REPORTED AT THIS TIME

Medicare/Medicaid Sanctions from DHHS: NO ACTIONS REPORTED AT THIS TIME

US DOJ Drug Enforcement Administration: NO ACTIONS REPORTED AT THIS TIME

U.S. Drug Enforcement Administration (DEA)

DEA Number*	Business Activity†	Drug Schedule	Activity	Expiration Date	Payment Indicator	Last Reported	Address
------843	C-0	22N 33N 4 5	Active	11/30/2023	Paid	04/27/2022	2300 N Florida Mango Rd

DEA Number*	Business Activity†	Drug Schedule	Activity	Expiration Date	Payment Indicator	Last Reported	Address
							West Palm Bch, FL 33409-6416

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

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

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

ECFMG certification

NOT APPLICABLE

Profile information

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

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

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

Client#: 943825 SOUTHWOM2

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/26/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: LaJeune Fitzpatrick	
USI Insurance Services LLC 2021 Spring Road, Suite 100 Oak Brook, IL 60523 312 442-7200	PHONE (A/C, No, Ext): 312 442-7200	FAX (A/C, No): 610 362-8900
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : General Star Indemnity Company	37362
INSURED South Wind Women's Center 5107 E. Kellogg Dr. Wichita, KS 67218	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?	N / A					E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$
A	Professional Liab			CONFIDENTIAL	10/21/2021	10/21/2022	1,000,000 Each Claim 3,000,000 Aggregate 5,000 Deductible	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Coverage is afforded to Shelly Tien, MD while acting within the scope of his/her duties.

CERTIFICATE HOLDER	CANCELLATION
Evidence of insurance	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE

From: Shelly Tien
To: Andrews, Michelle [KSBHA]
Subject: Copy of malpractice insurance
Date: Thursday, May 5, 2022 6:58:42 PM
Attachments: Malpractice insurance Trust Women Foundation.pdf

---

Hi Shelly,

CONFIDENTIAL

thank you!
Shelly Tien

CONFIDENTIAL

OFFICIAL RECEIPT
KANSAS BOARD OF HEALING ARTS
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612
(785) 296-7413

RECEIPT NUMBER: 700579 DATE: 06/15/2022

NAME:	LICENSE TYPE:	FEE:	LIC #:
Shelly Tien		300.00	
		47.00	
		3.00	

AMOUNT:
TYPE: Credit Card
CH/CC #: 092025

RECEIVED FROM:

Shelly Hsiao-Ying Tien

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612

State Board of Healing Arts

PHONE: 785-296-7413
FAX: 785-368-7103
KSBHA_healingarts@ks.gov
www.ksbha.org

Susan B Gile, Acting Executive Director

Laura Kelly, Governor

May 2, 2022

Shelly Hsiao-Ying Tien, MD

CONFIDENTIAL

Dear Shelly Hsiao-Ying Tien:

CONFIDENTIAL

Michelle Andrews
Licensing Analyst |Phone: 785-296-1926 |Email: Michelle.Andrews@ks.gov

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Uniform Application for Physician State Licensure	As of Date:4/12/2022

PRACTITIONER INFORMATION

Name:	Tien, Shelly Hsiao-Ying
DOB:	CONFIDENTIAL
Medical School:	Tufts University School of Medicine Boston, Massachusetts, UNITED STATES
Year of Grad:	2008
Degree Type:	MD
NPI:	1457500787

BOARD ACTIONS

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

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1457500787	Individual			11/06/2020

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Uniform Application for Physician State Licensure

As of Date:4/12/2022

Practitioner Name: Tien, Shelly Hsiao-Ying

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ALABAMA	00043189	09/22/2021	12/31/2022	03/22/2022
		FSMB License Status: Active		
ARIZONA	65210	12/27/2021	11/18/2023	03/29/2022
		FSMB License Status: Active		
FLORIDA	ME147816	11/12/2020	01/31/2023	03/14/2022
		FSMB License Status: Active		
ILLINOIS	125054448	05/21/2008	06/30/2011	03/29/2022
		FSMB License Status: Canceled		
ILLINOIS	036128275	06/29/2011	07/31/2023	03/29/2022
		FSMB License Status: Active		
MINNESOTA	55482	07/14/2012	07/31/2015	04/05/2022
		FSMB License Status: Inactive		
OKLAHOMA	37191	11/01/2020	11/01/2022	04/08/2022
		FSMB License Status: Active		

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Address	Last Reported
FT0907189	BIRMINGHAM,AL 35203	01/05/2022
FT3187843	WEST PALM BEACH,FL 33409	01/05/2022

PRACTITIONER PROFILE

Prepared for: Uniform Application for Physician State Licensure

As of Date:4/12/2022

Practitioner Name: Tien, Shelly Hsiao-Ying

ABMS® CERTIFICATION HISTORY

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

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2021	12/31/2022		Recertification	03/31/2022
Expired	Time Limited	12/31/2020	12/31/2021		Recertification	03/31/2022
Expired	Time Limited	12/31/2019	12/31/2020		Recertification	03/31/2022
Expired	Time Limited	04/13/2018	12/31/2019		Recertification	03/31/2022
Expired	Time Limited	12/31/2018	12/31/2019		Recertification	03/31/2022
Expired	Time Limited	12/31/2017	12/31/2018		Recertification	03/31/2022
Expired	Time Limited	12/31/2016	12/31/2017		Recertification	03/31/2022
Expired	Time Limited	12/31/2015	12/31/2016		Recertification	03/31/2022
Expired	Time Limited	12/31/2014	12/31/2015		Recertification	03/31/2022
Expired	Time Limited	12/06/2013	12/31/2014		Initial	03/31/2022

Certifying Board: American Board of Obstetrics and Gynecology
Certificate: Maternal-Fetal Medicine
Certification Type: Subspecialty
Certification Status: Certified
Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2021	12/31/2022		Recertification	03/31/2022
Expired	Time Limited	12/31/2020	12/31/2021		Recertification	03/31/2022
Expired	Time Limited	12/31/2019	12/31/2020		Recertification	03/31/2022
Expired	Time Limited	04/13/2018	12/31/2019		Initial	03/31/2022

PRACTITIONER PROFILE

Prepared for:	Uniform Application for Physician State Licensure	As of Date:4/12/2022
Practitioner Name:	Tien, Shelly Hsiao-Ying	

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) **The Kansas State Board of Healing Arts** to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. The fingerprints are authorized to be submitted under the authority of the National Childcare Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law 103-209 and Public Law 105-251. Pursuant to K.S.A. 22-4701 et seq. and K.S.A. 22-5001, the Authorized Recipient may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the above-referenced Authorized Recipient of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Authorized Recipient may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities until the criminal history background check is completed.

I understand that, upon my request, the Authorized Recipient will provide me a copy of the criminal history background report, received on me, for the purpose to challenge the accuracy and completeness of any information contained in any such report. I may be afforded a reasonable amount of time to correct or complete the criminal history record (or decline to do so) before the Authorized Recipient makes a final decision about my status as an employee, volunteer or contractor, or my eligibility for any pertinent license, certification or registration, or adoption. See 28 CFR 50.12(b).

I understand that officials receiving the results of the criminal history record check are to use those results only for authorized purposes and are prohibited from retaining or disseminating such results in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. (See 5 United States Code (USC) 552a(b); 28 USC 534(b); 42 USC 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), and 906.2(d).)

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C.534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).
Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:
Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other
information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

Routine Uses:
The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System

(Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:
The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

RIGHT TO OBTAIN AND CHALLENGE ACCURACY OF CRIMINAL HISTORY RECORDS

You may request a copy of your state and/or national criminal history record from the Authorized Recipient for the purpose of challenging for accuracy and completeness.

Alternatively, you may obtain a copy of your **Kansas criminal history record information** (CHRI) to review for accuracy and completeness, by submitting a set of your fingerprints, a letter requesting your criminal history record, and payment of the appropriate fee to the KBI. For further details, including the current fee, visit the following Internet website: http://www.kansas.gov/kbi/info/info_brochures.shtml then find the brochure named "Record Checks for Non-Criminal Justice Purposes". Or, to provide official court documents to make a correction you may write to:

Kansas Bureau of Investigation
Attn: Criminal History Records
1620 SW Tyler
Topeka, Kansas 66612-1837

If a change is made to your Kansas criminal history record due to a challenge, a new copy of your Kansas criminal history record will be sent to the Authorized Recipient to make a final decision about your status as an employee, volunteer or contractor, or your eligibility for any pertinent license, certification or registration, or adoption.

To obtain a copy of your **national CHRI, also known as the Identity History Summary**, for review and challenge you must submit a set of your fingerprints and the appropriate fee to the FBI. Information regarding this process may be obtained at: https://www.fbi.gov/services/cjis/identity-history-summary-checks. Or, you may write to:

FBI CJIS Division
Attn: Criminal History Analysis Team 1
1000 Custer Hollow Road
Clarksburg, West Virginia 26306

State of Alabama
Medical Licensure Commission

Craig H. Christopher, M.D., Chairman/Executive Officer
Karen Silas, Director of Operations

04/18/2022

Kansas State Board of Healing Arts
800 SW Jackson Street
Lower Level, Suite A
Topeka, KS 66612

VERIFICATION OF ALABAMA MEDICAL LICENSURE

Name of Licensee (as it appears in our Records)
Shelly Hsiao-Ying Tien

Date of Birth: CONFIDENTIAL
License Number: **MD.43189**
Current Status: **Active**
Date Issued: **09/22/2021**
Basis of License: **USMLE/IL**
Expiration Date: **12/31/2022**
Medical School: **Tufts University School of Medicine**
Location: **Boston**
Date From/To: **08/03-05/08**

Disciplinary Actions:

[X] No

[ ] Yes, visit Public Actions at www.albme.gov for documents.

Signature: Craig H Christopher M.D.

Craig H. Christopher, M.D. Chairman
Medical Licensure Commission of Alabama

To expedite the verification process, the above is the standard format used by the Medical Licensure Commission of Alabama. Verification information can also be obtained by accessing our website at http://www.albme.gov.

From: bme@albme.gov
To: KSBHA_Licensing; hlindemann@almlc.gov
Subject: License Verification from AL BME and AL MLC
Date: Monday, April 18, 2022 7:42:22 AM
Attachments: verification.pdf

To Whom it May Concern:

Please see the attached medical license verification from the state of Alabama.

Thank you,

Alabama Medical Licensure Commission
PO Box 887, Montgomery, AL 36101
848 Washington Ave., Montgomery, AL 36104
Telephone: 334-242-4153
Email: MLC@almlc.gov

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Mario Treto, Jr.
Acting Secretary

Cecilia Abundis
Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

2650 RIDGE AVE
EVANSTON, IL 60201

Licensee: License Number:	SHELLY HSIAO-YING TIEN MD 036.128275
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	06/29/2011
Expiration Date:	07/31/2023
License Status:	ACTIVE
License Method:	LIC BY EXAM
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 04/17/2022

Cecilia Abundis
Director
Division of Professional Regulation

04/17/2022
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

From:	IL Department of Financial/Professional Regulation
To:	SHELLY HSIAO-YING TIEN MD; KSBHA_Licensing
Subject:	IDFPR Official Certification of Licensure
Date:	Sunday, April 17, 2022 9:10:36 AM
Attachments:	License Certificate Print - 036.128275.pdf

To whom it may concern,

Attached to this email is the Illinois Department of Financial and Professional Regulation's Official ***Certification of Licensure*** for:

Board: Illinois Medical Board

Profession: LICENSED PHYSICIAN AND SURGEON

Licensee Name: SHELLY HSIAO-YING TIEN MD

License Number: 036.128275

As of: 04/17/2022

Thank you and please contact the Department if any questions may arise.

Illinois Department of Financial and Professional Regulation

Phone: 1 (800) 560-6420

https://www.idfpr.com/

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Mario Treto, Jr.
Acting Secretary

Cecilia Abundis
Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

Evanston Hospital
2650 Ridge Ave
Evanston, IL 60201-1718

Licensee: License	SHELLY HSIAO-YING TIEN MD
Number:	336.104674
Profession:	LICENSED PHYSICIAN CONTROLLED SUBSTANCE
Date of Issuance:	06/05/2017
Expiration Date:	07/31/2023
License Status:	ACTIVE
License Method:	NON-EXAM
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 04/17/2022

Cecilia Abundis
Director
Division of Professional Regulation

04/17/2022
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

From:	IL Department of Financial/Professional Regulation
To:	SHELLY HSIAO-YING TIEN MD; KSBHA_Licensing
Subject:	IDFPR Official Certification of Licensure
Date:	Sunday, April 17, 2022 9:10:37 AM
Attachments:	License Certificate Print - 336.104674.pdf

To whom it may concern,

Attached to this email is the Illinois Department of Financial and Professional Regulation's Official ***Certification of Licensure*** for:

Board: Illinois Medical Board

Profession: LICENSED PHYSICIAN CONTROLLED SUBSTANCE

Licensee Name: SHELLY HSIAO-YING TIEN MD

License Number: 336.104674

As of: 04/17/2022

Thank you and please contact the Department if any questions may arise.

Illinois Department of Financial and Professional Regulation

Phone: 1 (800) 560-6420

https://www.idfpr.com/

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Mario Treto, Jr.
Acting Secretary

Cecilia Abundis
Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

4140 27th Ave S
Minneapolis, MN 55406-3048

Licensee: License Number:	SHELLY HSIAO-YING TIEN MD 336.090117
Profession:	LICENSED PHYSICIAN CONTROLLED SUBSTANCE
Date of Issuance:	08/09/2011
Expiration Date:	07/31/2017
License Status:	NOT RENEWED
License Method:	NON-EXAM
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 04/17/2022

Cecilia Abundis
Director
Division of Professional Regulation

04/17/2022
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

From:	IL Department of Financial/Professional Regulation
To:	SHELLY HSIAO-YING TIEN MD; KSBHA_Licensing
Subject:	IDFPR Official Certification of Licensure
Date:	Sunday, April 17, 2022 9:10:38 AM
Attachments:	License Certificate Print - 336.090117.pdf

To whom it may concern,

Attached to this email is the Illinois Department of Financial and Professional Regulation's Official ***Certification of Licensure*** for:

Board: Illinois Medical Board

Profession: LICENSED PHYSICIAN CONTROLLED SUBSTANCE

Licensee Name: SHELLY HSIAO-YING TIEN MD

License Number: 336.090117

As of: 04/17/2022

Thank you and please contact the Department if any questions may arise.

Illinois Department of Financial and Professional Regulation

Phone: 1 (800) 560-6420

https://www.idfpr.com/

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Mario Treto, Jr.
Acting Secretary

Cecilia Abundis
Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

ADVOCATE ILLINOIS MASONIC
MED CTR
MEDICAL EDUCATION DEPT

Licensee: License	SHELLY HSIAO-YING TIEN MD
Number:	125.054448
Profession:	TEMPORARY MEDICAL PERMIT
Date of Issuance:	05/21/2008
Expiration Date:	06/30/2011
License Status:	CANCELLED
License Method:	NON-EXAM
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 04/17/2022

Cecilia Abundis
Director
Division of Professional Regulation

04/17/2022
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

From:	IL Department of Financial/Professional Regulation
To:	SHELLY HSIAO-YING TIEN MD; KSBHA_Licensing
Subject:	IDFPR Official Certification of Licensure
Date:	Sunday, April 17, 2022 9:10:38 AM
Attachments:	License Certificate Print - 125.054448.pdf

To whom it may concern,

Attached to this email is the Illinois Department of Financial and Professional Regulation's Official ***Certification of Licensure*** for:

Board: Illinois Medical Board

Profession: TEMPORARY MEDICAL PERMIT

Licensee Name: SHELLY HSIAO-YING TIEN MD

License Number: 125.054448

As of: 04/17/2022

Thank you and please contact the Department if any questions may arise.

Illinois Department of Financial and Professional Regulation

Phone: 1 (800) 560-6420

https://www.idfpr.com/

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Mario Treto, Jr.
Acting Secretary

Cecilia Abundis
Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

Evanston Hospital
2650 Ridge Ave
Evanston, IL 60201-1718

Licensee: License	SHELLY HSIAO-YING TIEN MD
Number:	336.104674
Profession:	LICENSED PHYSICIAN CONTROLLED SUBSTANCE
Date of Issuance:	06/05/2017
Expiration Date:	07/31/2023
License Status:	ACTIVE
License Method:	NON-EXAM
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 04/17/2022

Cecilia Abundis
Director
Division of Professional Regulation

04/17/2022
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

From:	IL Department of Financial/Professional Regulation
To:	SHELLY HSIAO-YING TIEN MD; KSBHA_Licensing
Subject:	IDFPR Official Certification of Licensure
Date:	Sunday, April 17, 2022 9:10:38 AM
Attachments:	License Certificate Print - 336.104674.pdf

To whom it may concern,

Attached to this email is the Illinois Department of Financial and Professional Regulation's Official ***Certification of Licensure*** for:

Board: Illinois Medical Board

Profession: LICENSED PHYSICIAN CONTROLLED SUBSTANCE

Licensee Name: SHELLY HSIAO-YING TIEN MD

License Number: 336.104674

As of: 04/17/2022

Thank you and please contact the Department if any questions may arise.

Illinois Department of Financial and Professional Regulation

Phone: 1 (800) 560-6420

https://www.idfpr.com/

Arizona Medical Board

General Information

Shelly H. Tien
2424 North Wyatt Drive
Suite 260
Tucson AZ 85712
Phone: (520) 795-8080

License Number: 65210
License Status: Active
License Date: 12/27/2021
License Renewed: 12/27/2021
Due to Renew By: 07/18/2023
If not Renewed, License Expires: 11/18/2023

Education and Training

Medical School:
Graduation Date:

Area of Interest:	Obstetrics & Gynecology
Area of Interest:	Maternal & Fetal Medicine (Obstetrics & Gynecology)

The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

Board Actions

None

This license information was last updated on: 04/16/2022

A person may obtain additional public records related to any licensee, including dismissed complaints and non-disciplinary actions and orders, by making a written request to the Board. The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

Please note that some Board Actions may not appear until a few weeks after they are taken, due to appeals, effective dates and

Board actions taken against physicians in the past 24 months are also available in a chronological list.

April 17, 2022

Kansas State Board of Healing Arts
800 SW Jackson
Lower Level-Suite A
Topeka, KS 66612

RE: License Certification for Shelly Tien

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:	Medical Doctor
LICENSE NUMBER:	ME147816
ORIGINAL CERTIFICATION:	11/12/2020
EXPIRATION DATE:	01/31/2023
CURRENT STATUS OF LICENSE:	CLEAR, ACTIVE
AGENCY ACTION:	None

This license information was last updated on: 04/17/2022

To expedite the verification process, the above format is the standard format for all healthcare practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595.

MINNESOTA
BOARD OF MEDICAL PRACTICE

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

April 17, 2022

Kansas State Board of Healing Arts
800 SW Jackson
Lower Level-Suite A
Topeka, KS 66612

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

Physician:	Shelly Hsiao-Ying Tien
Date of birth:	CONFIDENTIAL
Was issued license number:	55482
On:	July 14, 2012
Expiration date is:	July 31, 2015
Status:	Resigned Inactive
Issued on the basis of:	USMLE - United States Med Lic Exam
Corrective action:	None
Disciplinary action:	None

Licensure History:

TP106031 -Temporary Permit Issued:April 16, 2012 Expired: July 14, 2012

This license information was last updated on: 4/12/2022 12:00:00AM

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

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

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

Sincerely,

Ruth M. Martinez
Executive Director

Board of Medical Licensure & Supervision
State of Oklahoma

101 N.E. 51st Street
Oklahoma City, OK 73105

P.O. Box 18256
Oklahoma City, OK 73154-0256

Letter of Verification

April 17, 2022

This is to certify that the records of this Board indicate on the date of this letter the following information regarding:

Name:	SHELLY TIEN
Address Date:	September 23, 2021
Address 1:	TRUST WOMEN
Address 2:	1240 SW 44TH ST
Address 3:	
City, State, ZIP:	OKLAHOMA CITY, OK 73109

Profession:	MEDICAL DOCTOR
Profession Type:	MD
License Number:	37191
License Date:	11/01/2020
Status:	Active
Status Class:	
Expiration Date:	11/01/2022
Endorsed By:	USMLE
Restricted To:	

Disciplinary Actions:

Date	Description
No Disciplinary Actions Taken	

Previous Licenses:

Type	Issued	Expired

Details of Disciplinary Action, if applicable, will be made available by photocopy from the public file upon written request only.

To expedite the verification of licensure/certification process, the above is the standard format for all professions regulated by this board

The Oklahoma State Board of Medical Licensure and Supervision certifies that the verification data displayed here is accurate according to the information stored in our database as of 04/17/2022.

Lisa Cullen
Director of Licensing
(405) 962-1400 ext 153

From:	support@veridoc.org
To:	KSBHA_Licensing
Subject:	License Verification Statement - TIEN, SHELLY
Date:	Sunday, April 17, 2022 8:49:49 AM
Attachments:	v988867AA.pdf v988867BA.pdf v988867CA.pdf v988867DA.pdf

Verification of Licensure Status

The attached verification reports have been sent to you by the VeriDoc.org website. This email can be verified coming from this site by clicking on the link below.

Validate Verifications

Physician: TIEN, SHELLY

Transaction ID: 988867

CONFIDENTIAL

This email contains 4 PDF attachments. If any are missing please contact support@veridoc.org.

Information from the attached verifications can be refreshed for up to 6 months. To view an updated copy, click on a link below.
Arizona Medical Board
Florida Board of Medicine
Minnesota Board of Medical Practice
Oklahoma Board of Medical Licensure & Supervision

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level, Suite A
Topeka, KS 66612

Phone: 785-296-7413
www.ksbha.org

KANSAS
BOARD OF HEALING ARTS

KANSAS LICENSURE APPLICATION ADDENDUM INSTRUCTIONS MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY(DO)

Please visit www.ksbha.org for all statutes and regulations

Completing the Kansas Licensure Addendum

Complete each addendum as instructed. Please type or print your responses. Return the completed addenda along with any and all supporting documentation to the Kansas State Board of Healing Arts at the address above.

☑ **Addendum 1** — These questions must be completed by the applicant.

☑ **Addendum 2** — Each question must be completed by the applicant. Documentation must be provided for any "yes" answer(s). **It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

☐ **Addendum 3** — This form must be completed by the applicant. All applicants for licensure in the State of Kansas must request a disciplinary inquiry report from the Federation of State Medical Boards (FSMB). Once this form has been completed, you may email it to the FSMB at boardinquiry@fsmb.org.

If you are using FCVS, do not complete this form. They will obtain your disciplinary report and send it to the Board.

☑ **Addendum 4** — Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks. Addendum 4 explains in detail how to obtain and submit fingerprints to the Board.

Complete, sign and date the top portion of Waiver Agreement and FBI Privacy Act Statement. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without completed and signed Waiver Agreement. Submit completed background check waiver, Fingerprint card, and $47 fee.

Be aware that fingerprint processing may delay your application. Please make it a priority to complete the fingerprint process.

☑ **Credit Card Payment Authorization Form** — To pay by debit or credit card, complete the Credit Card/Debit Card Authorization Form.

Application fees must be submitted with the application. These *fees are **non-refundable*** and will be processed upon receipt. The Kansas Medicine and Surgery application fee is **$300**. Also, a background check fee of **$47** and a National Practitioner Data Bank ("NPDB") report fee of **$3** must accompany the application. **This totals $350.**

RECEIVED
APR 21 2022
KSBHA

ADDENDUM 3
KANSAS STATE BOARD OF HEALING ARTS

Applicant: Complete this form and email it to boardinquiry@fsmb.org. You must also check the box below.

☑ I hereby certify that I am the individual referenced below and I acknowledge that I have answered all questions and reported all information on this page truthfully and completely.

Federation of State Medical Boards of the United States, Inc.
400 Fuller Wiser Road, Suite 300 | Euless, TX 76039
Tel (817) 868-4000 Fax (817) 868-4099

Physician Data Center Inquiry Form

Attention: State Board Inquiries

The Kansas State Board of Healing Arts is requesting a PDC Search concerning the following individual:

Last Name	Tien
First Name	Shelly
Middle Name	Hsiao-Ying
Date of Birth	CONFIDENTIAL
Daytime Phone	
Email	
Degree (MD, DO, or PA only)	MD
Medical School	Tufts University School of Medicine
Year of Graduation	2008
Last Four Digits of Social Security Numbe	CONFIDENTIAL
ECFMG # (if applicable)	
NPI Number	1457500787

Please mail the result to the following address:

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level – Suite A
Topeka, KS 66612

RECEIVED
APR 21 2022
KSBHA

CONFIDENTIAL

CONFIDENTIAL

From: O"Neal, Nicole
To: Andrews, Michelle [KSBHA]
Cc: CONFIDENTIAL
Subject: Shelly Tien Transcript
Date: Friday, May 6, 2022 10:26:06 AM
Attachments: Tien, Shelly.pdf

RE: Shelly Tien

Please see attached. If I can be of further assistance, let me know.

Have a great rest of your day,

Nicole O'Neal (she series)
Administrative Coordinator
Office of Student Affairs/Registrar's Office
Tufts University School of Medicine
145 Harrison Avenue
Boston, MA 02111
PH: (617) 636-6569 FAX: (617) 636-0432
TUSM Registrar