

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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

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

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

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

- A. Type or print legibly with black ink only.
- B. **FEES ARE NOT REFUNDABLE.**
- C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

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

1. PROFESSION NAME <i>Visiting Physician Permit</i>	2. PROFESSION CODE <u>1 0 6</u>	3. LICENSURE METHOD <i>Non-examination</i>	4. FEE \$ 100.00
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B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- | | |
|--|--|
| <input checked="" type="checkbox"/> This is the first time I have made application for this profession in Illinois.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

<input type="checkbox"/> Other: _____ | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language. |
|--|--|

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

1. NAME LAST FIRST MIDDLE <i>Riley, Regan E.</i>	2. TITLE (e.g., M.D., D.D.S., etc.) <i>DO</i>	3. UNITED STATES SOCIAL SECURITY NO. [REDACTED]
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4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY [REDACTED]	ZIP CODE [REDACTED]	COUNTY [REDACTED]
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5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY <i>2211 Lomas Blvd NE Albuquerque NM</i>	ZIP CODE <i>87131</i>	COUNTY <i>Bernalillo</i>
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6. MAIDEN GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE) <i>N/A</i>	7. MOTHER'S MAIDEN NAME <i>Anderson</i>
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8. PLACE OF BIRTH CITY STATE/COUNTRY <i>Seattle, WA USA</i>	9. DATE OF BIRTH [REDACTED] Month Day Year	10. AGE <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male <i>37</i>
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11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: <i>(505) 925-4455</i> Home: [REDACTED] Fax: [REDACTED] Fax: [REDACTED]	12. REQUIRED E-MAIL ADDRESS [REDACTED]
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NAME (Last, First, MI): Riley Regan E
 SS#:
 Profession: visiting physician

PART III: Education Information

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

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

Graduated

High School?

Yes No

Received

OR G.E.D.?

Yes No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED

Inglemoor High School

3. LAST PRELIMINARY SCHOOL LOCATION (City and State)

Bothell, Washington

4. DATE OF GRADUATION

06 / 11 99 8
 Month Year

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

1 2 3 4 5 6 7 8 +

Graduated?

Yes No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)

LOCATION (City and State or Country)

DATES OF ATTENDANCE FROM TO

TYPE OF DEGREE EARNED

Baylor University

Miami Shores, Florida

Month/Year

Month/Year

08/1998

06/2002

BS

University of New England

Biddeford, Maine

09/2007

06/2009

MPH

Arizona College of Osteopathic Medicine

Glendale, Arizona

08/2009

06/2013

DO

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

INSTITUTION NAME

LOCATION (City and State or Country)

DATES OF ATTENDANCE FROM TO

Did You Complete Training?

Florida College of Natural Health (massage)

Pompano Beach, Florida

Month/Year

Month/Year

09/2002

03/2003

Yes No

University of New Mexico (residency)

Albuquerque, New Mexico

07/2013

06/2017

Yes No

Yes No

Yes No

Yes No

NAME (Last, First, MI):

Riley, Reagan, E.

SS#:

Profession:

Visiting physician

PART IV: Record of Licensure Information

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure New Mexico	Osteopathic Physician	A-2032-17	3.14.17	Active
State of Current Licensure where you most recently have been practicing. New Mexico	Resident Physician	R07-2013		Expired
Other States of Licensure				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
USMLE Step 1	Arizona	06/2011	[REDACTED]
COMLEX Level 1	Arizona	06/2011	
USMLE Step 2 CK	Washington	06/2012	
COMLEX Level 2	Washington	07/2012	
COMLEX Level 2 PE	Pennsylvania	09/2012	
COMLEX Level 3	New Mexico	04/2015	

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

Regan Riley
DOB [REDACTED]

Part V: Record of Examination continued

- USMLE Step 2 CS - ^{California}~~New Mexico~~ - 04/2015 - [REDACTED]
- USMLE Step 3 - New Mexico - 11/2015 - [REDACTED]
- ABOG Qualifying Exam - New Mexico - 6/2017 - [REDACTED]

Riley, Regan, E

visiting physician

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**ILLINOIS DEPARTMENT OF FINANCIAL
AND PROFESSIONAL REGULATION
PERSONAL HISTORY INFORMATION**

SUPPORTING DOCUMENT

PH

NAME	LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
	Riley	Regan	E	[REDACTED]

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

Certification Statement

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

Signature of Applicant

1.17.18

Date

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HEALTH CARE WORKERS CHARGED WITH OR CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE Riley Ryan E	3. PROFESSIONAL LICENSE NUMBER (if any) _____
2. ADDRESS STREET, CITY, STATE, ZIP CODE _____	4. SOCIAL SECURITY NUMBER _____

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

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

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

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

- | | | |
|---|--------------------------|-------------------------------------|
| 1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? * | Yes | No |
| | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2) Are you currently charged with or have you been convicted of a criminal battery against any patient <i>in the course of patient care or treatment</i> , including any offense based on sexual conduct or sexual penetration? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? * | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4) Are you currently charged with or have you been convicted of a forcible felony? * | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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

Certification Statement

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

Signature of Applicant

1-17-18

Date

5

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CERTIFICATION OF INVITATION/APPOINTMENT FOR VISITING PHYSICIAN 180-DAY PERMIT

SUPPORTING DOCUMENT

MD-VPH

NOTE: An applicant shall not commence the appointment before the program receives written notification of approval from the Department of Financial and Professional Regulation.

A Visiting Physician Permit issued pursuant to Section 18(B) of the Medical Practice Act, shall be valid for 180 days from the date of issuance or until the time the medical, osteopathic, chiropractic, or clinical studies or techniques are completed, whichever occurs first. The applicant may be required to appear before the Board for an interview prior to, and as a requirement for, the issuance of such visiting physician permit.

APPLICANT: Complete the applicant section of this form. Forward the form to the dean or program director of the school or hospital at which the invitation/appointment has been established. Return the completed form with the Application for Licensure/Examination at least 60 days prior to the beginning date of the invitation/appointment.

1. NAME LAST FIRST MIDDLE: Riley Regan E; 2. DATE OF BIRTH; 3. SOCIAL SECURITY NUMBER; 4. ADDRESS STREET, CITY, STATE, ZIP CODE; 5. MAIDEN OR GIVEN SURNAME: Riley; Visiting Physician Permit 106 Profession Name Profession Code

DEAN OR PROGRAM DIRECTOR OF SCHOOL OR HOSPITAL: Complete the remainder of this form, then return the form to the applicant.

A. NAME OF MEDICAL, OSTEOPATHIC, CHIROPRACTIC SCHOOL OR HOSPITAL: Family Planning Associates Medical; B. THE TERM OF CONTRACT NOT TO EXCEED 180 DAYS: From 06/01/2018 To 08/01/2018; C. NAME OF DEPARTMENT OF SCHOOL OR HOSPITAL: Group Family Planning; D. TELEPHONE NUMBER: 312-707-8988; E. LOCATION OF SCHOOL OR HOSPITAL: 659 W. Washington Blvd Chicago IL 60661; F. FAX NUMBER: 312-707-9223

G. DESCRIBE IN DETAIL THE NATURE OF CLINICAL SUBJECT OR TECHNIQUE THAT APPLICANT HAS BEEN INVITED/APPOINTED TO STUDY, DEMONSTRATE, OR PERFORM. DR. Riley has been invited for a month rotation to perform abortion procedures and contraceptive care in our facility under the direction of our medical staff. RECEIVED APR 6 2018

I do hereby declare that the above-named applicant has been invited/appointed to study, demonstrate or perform a specific clinical subject or technique as a visiting physician for 180 days or until such time as the clinical studies or techniques have been completed, whichever occurs first.



APR 06 2018

Signature of Dean or Program Director

4/4/18 IDFPR - MEDICAL A. Cowett MD

Print or Type Name of Dean or Program Director



FAMILY PLANNING ASSOCIATES MEDICAL GROUP

659 W. Washington St., Chicago, Illinois 60661
(312) 707-8988

Allison A. Cowett, MD MPH
Director of Visiting Physicians Program
Associate Medical Director
Family Planning Associates Medical Group
659 West Washington Blvd.
Chicago, IL 60661

April 4, 2018

Department of Financial and Professional Regulation
Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, IL 62786

Dear Sir or Madam:

Family Planning Associates Medical Group does not have a seal to affix to Regan Riley's MD-VPH Form as part of her Visiting Physician 180-day permit. Please find the included MD-VPH Form, which has been notarized with my signature.

Please contact me with any questions.

Sincerely,


Allison Cowett, MD MPH

RECEIVED
APR 06 2018
IDFPR - MEDICAL UNIT



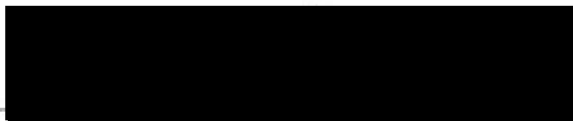
VERIFICATION OF STATE LICENSURE

- A. Licensee Name: Regan Elizabeth Riley
- B. License Number: A-2032-17
- C. License Type: Doctor of Osteopathy
- D. Date License Issued: 03/14/2017
- E. License expiration date: 07/01/2018
- Active Inactive Expired
- G. Has license ever been suspended or revoked? Yes No
 If Yes, explanation:

- H. Is licensee presently under an investigation or disciplinary action?
 Yes No If yes, explanation:

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 MAY 18 2018
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Signature: _____



Title: Administrative Assistant

Date: January 29, 2018



State of New Mexico
Regulations and Licensing Department
Board and Commissions

2550 Cerrillos Rd. 2nd Floor, Santa Fe, NM 87505



ATTENTION

The attached document is an official
State of New Mexico licensure verification/certification

This verifies the named individual has met all of the
education/examination requirements by law in order to
receive the credential that is being verified.

Specific examination status in certificates/verifications
of licensure is not included when passage of an
examination is a requirement for licensure.

This information is the ONLY certification information
provided by this Board. If other information is needed.

RECEIVED

MAY 1 8 2013

IDFPR - MEDICAL UNIT



New Mexico Regulation and Licensing Department
BOARDS AND COMMISSIONS DIVISION
Board of Osteopathic Medical Examiners

Toney Anaya Building • 2550 Cerrillos Road • Santa Fe, New Mexico 87505
(505) 476-4622 • Fax (505) 476-4665 • www.RLD.state.nm.us/boards

VERIFICATION OF STATE LICENSURE

A. Licensee Name: Regan Elizabeth Riley

B. License Number: A-2032-17

C. License Type: Doctor of Osteopathy

D. Date License Issued: 03/14/2017

E. License expiration date: 07/01/2018

Active Inactive Expired

G. Has license ever been suspended or revoked? Yes No
If Yes, explanation:

H. Is licensee presently under an investigation or disciplinary action?
 Yes No If yes, explanation:

Signature: _____

Title: Administrative Assistant

Date: January 29, 2018

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APR 24 2018

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Education

- July 2017 – June 2019 **University of New Mexico – Albuquerque, NM**
(Anticipated) Family Planning Fellowship
- July 2013 - June 2017 **University of New Mexico – Albuquerque, NM**
Obstetrics and Gynecology Residency
- Aug 2009 - June 2013 **Arizona College of Osteopathic Medicine, Midwestern University – Glendale, AZ**
Doctor of Osteopathic Medicine
- Aug 2007 - June 2009 **University of New England – Biddeford, ME**
Master of Public Health
Thesis Topic: Adolescents, Nutrition, and Bone Health
- Sept 2002 - April 2003 **Florida College of Natural Health – Pompano Beach, FL**
Massage Practitioner Certificate
- Aug 1998 - June 2002 **Barry University – Miami Shores, FL**
Bachelor of Science in Sports Medicine

Licensure and Certifications

- New Mexico Osteopathic Medical License #A-2032-17
DEA # (*information available, per request*)
NPI # 1174865869
ACLS – Exp 02/2019
BLS – Exp 02/2019
Moderate Sedation Training – Completed 04/2017

Honors and Awards

- 2016 Ervin W. Lewis Resident Teaching Award: University of New Mexico
-Medical school class of 2016 elects one resident across all departments who contributed substantially to their educational experience
- 2015 AAMC Teaching for Quality (Te4Q) Certification
- 2015 Gold Humanism Honor Society: University of New Mexico
- 2014 - 2017 Medical Student Teaching Award: University of New Mexico
- 2014 Intern of the Year: University of New Mexico
- 2010, 2011 Volunteer Service Excellence Award: Arizona College of Osteopathic Medicine
- 2007 – 2009 Dean’s List: University of New England
- 2003 Valedictorian: Florida College of Natural Health
- 2002 NFCA All-America Scholar-Athlete: Barry University
- 2002 Terry Badia Award (most inspirational student-athlete): Barry University
- 1999 – 2002 Athletic Directors Honor list & Dean’s List: Barry University

Leadership Roles

2016 – Current	Gold Humanism Honor Society Selection Committee Member
2016 – 2017	American Congress of Obstetricians & Gynecologists, District VIII Junior Fellow Legislative Chair
2015 – 2017	Medical Student Continuity Clinic Preceptor
2015 – 2017	GME Resident Patient Safety and Quality Improvement Committee member
2015 – 2017	OB/Gyn Executive Committee on Patient Safety and Quality Improvement, Resident Liaison
2015 – 2016	American Congress of Obstetricians & Gynecologists, District VIII Junior Fellow Chair
2015 – 2016	American Congress of Obstetricians & Gynecologists, District VIII Junior Fellow Advocacy Committee Chair
2014 – 2016	Selected to interview applying faculty as resident representation
2014 – 2016	Selected to interview with site reviewer for MFM and FP Fellowship accreditation visits
2014 – 2016	Resident School Curriculum Committee member
2014 – 2015	American Congress of Obstetricians & Gynecologists, District VIII Junior Fellow Vice Chair
2013 – 2017	Rotation, vacation, and call scheduler for resident class
2012 – 2013	National Officer: Vice Chair, Medical Student Osteopathic Surgical Association
2011 – 2012	National Officer: Treasurer, Medical Student Osteopathic Surgical Association
2010 – 2011	Vice President, AZCOM Chapter, National Osteopathic Women Physicians Association
2010 – 2011	Treasurer, AZCOM Chapter, Medical Student Osteopathic Surgical Association
2009 – 2013	Mentor to Pre-Medical Students, Washington Osteopathic Medical Association
2000 – 2002	Team Captain for NCAA Division II Softball Team

Professional Society Memberships

2016 – Current	American Society of Professionals in Patient Safety (ASPPS)
2015 – Current	Society of Family Planning
2011 – Current	American Congress of Obstetricians & Gynecologists (ACOG)
2011 – Current	American College of Osteopathic Obstetricians & Gynecologists (ACOOG)
2009 – Current	American Medical Association (AMA)
2009 – Current	American Osteopathic Association (AOA)
2009 – Current	Washington Osteopathic Medical Association (WOMA)

Invited Lectures & Presentations

1. September 11, 2018. *Post Partum IUDs and LARC*. Presbyterian Health Systems Obstetrics and Gynecology Grand Rounds. Albuquerque, NM. (Anticipated)
2. April 22, 2018. *Case Presentation – Break Out Session*. National Abortion Federation. Seattle, WA. (Anticipated)
3. March 22, 2018. *Hands on Contraception*. Indigenous Women’s Conference. Albuquerque, NM. (Anticipated)
4. February 12, 2018. *Post Partum IUDs and LARC*. Reproductive Health TeleECHO. Albuquerque, NM. (Anticipated)
5. October 13, 2017. *Provider Perceptions of Early Postpartum IUDs*. Family Planning Fellow research proposal presentation. Society of Family Planning, North American Forum. Atlanta, GA. (Presented by Dr. Lisa Hofler)
6. September 14, 2016. University of New Mexico, *Resident Quality Improvement Education Curriculum*. Resident Quality Improvement and Patient Safety Conference. Albuquerque, NM.

7. June 10, 2016. University of New Mexico, *Morbidity & Mortality: A Time for Change*. Annual OB/Gyn Research Day. Albuquerque, NM.
8. February 27th, 2016. *New Mexico Section Report*. American Congress of Obstetricians & Gynecologists, Interim District Meeting, District VIII. Albuquerque, NM.
9. September 19th, 2015. *New Mexico Section Report*. American Congress of Obstetricians & Gynecologists, Annual District Meeting, District VIII. Denver, CO.

Conferences Attended

1. Family Planning Fellowship Annual Meeting. San Diego, CA, May 2017.
2. Presbyterian Wiggins' Obstetrics & Gynecology Conference. Albuquerque, NM, November 2016.
3. Resident Quality Improvement Retreat. Albuquerque, NM, June 2016.
4. American Congress of Obstetricians & Gynecologists, Interim District Meeting, District VIII. Albuquerque, NM, February 2016.
5. New Mexico Section of ACOG, Women's Health Conference. Albuquerque, NM, February 2016.
6. Society of Family Planning, North American Forum. Chicago, IL, November 2015.
7. Presbyterian Wiggins' Obstetrics & Gynecology Conference. Albuquerque, NM, November 2015.
8. American Congress of Obstetricians & Gynecologists, Annual District Meeting, District VIII. Denver, CO, September 2015.
9. American Congress of Obstetricians & Gynecologists, Congressional Leadership Conference. Washington, DC, March 2015.
10. American Congress of Obstetricians & Gynecologists, Section Officer Leadership Development Program. Washington, DC, March 2015.
11. American Congress of Obstetricians & Gynecologists, Interim District Meeting, District VIII. Panama City, Panama, February 2015.
12. New Mexico Section of ACOG, Women's Health Conference. Albuquerque, NM, February 2015.
13. Presbyterian Wiggins' Obstetrics & Gynecology Conference. Albuquerque, NM, November 2014.
14. New Mexico Section of ACOG, Women's Health Conference. Albuquerque, NM, February 2014.
15. Presbyterian Wiggins' Obstetrics & Gynecology Conference. Albuquerque, NM, November 2013.

Research Projects

2017 – Current

Provider Perceptions of Early Postpartum IUDs (PPEPPI)

The objective of this study is to evaluate the provider perception of the 2 to 4 week early postpartum IUD in addition to the 2 to 4 week postpartum visit. This qualitative study is nested within a multisite randomized controlled study.

Faculty Research Mentors: Lisa Hofler, MD, MPH, MBA and Eve Espey, MD, MPH
University of New Mexico

Status: Concept approved and presented, proposal pending

Awarded Family Planning Grant for fellow research project

Anticipate completion and manuscript submission by May 2019

- 2015 – 2017 **Quality and Safety Project for Resident Training (SPORT)**
The objective of this study was to evaluate resident satisfaction and perceived educational value after the creation and implementation of Quality Improvement and Patient Safety curriculum.
Faculty Research Mentor: Gena Dunivan, MD
University of New Mexico
Status: Presented to AAMC Teaching for Quality Conference
Certificate of completion of AAMC Teaching for Quality (Te4Q)
Curriculum began August 2016
- 2015 – 2016 **Morbidity and Mortality Conference: A Time for Change**
The objective of this study was to evaluate satisfaction, perceived educational value, and safety culture after restructuring the morbidity and mortality conference.
Faculty Research Mentor: Teresa Rutledge, MD
University of New Mexico
Status: Presented at Annual Resident Research Day in May 2016
Awarded Scholarship in Education Allocations Committee (SEAC) Grant
- 2013 - 2015 **Nitrous Oxide for Pain Control in Outpatient Gynecologic Procedures: An RCT**
The objective of this study was to evaluate whether inhaled nitrous oxide is superior to oral sedation for pain management during in-office hysteroscopic sterilization.
Faculty Research Mentor: Rameet Singh, MD
Fellow Research Mentor: Emily N. Schneider, MD
University of New Mexico
Status: Presented at Fellowship in Family Planning Annual Meeting
Published on Contraception
- 2009 **Case-Control study on Adolescents, Nutrition, and Bone Health**
The objective of this study was to compare diets and exercise routines in adolescents with and without bone pathology.
Master of Public Health Thesis
Faculty Research Mentor: Michele Polacsek, PhD, MHS
University of New England
Status: Presented to Thesis Defense Committee

Grants

1. Scholarship in Education Allocations Committee (SEAC) Grant
Investigators: RE Riley, PI: TR Rutledge, GC Dunivan, EM Gordon
Sponsor: University of New Mexico Office for Medical Educator Development
Amount: FUNDED- as patient safety project (\$2,500)
Study Dates: 7/01/2015-6/30/2016

PRACTITIONER PROFILE

Prepared for: Illinois Division of Professional Regulation As of Date: 3/22/2018

PRACTITIONER INFORMATION

Name: Riley, Regan Elizabeth
Alternate Name(s): Riley, Regan E
DOB: [REDACTED]
Medical School: Midwestern University, Arizona Campus
Glendale, Arizona, UNITED STATES
Year of Grad: 2013
Degree Type: DO
NPI: 1174865869

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
NEW MEXICO OSTEO	A-2032-17	3/14/2017	7/1/2018	2/23/2018

PRACTITIONER PROFILE

Prepared for: Illinois Division of Professional Regulation As of Date:3/22/2018
Practitioner Name: Riley, Regan Elizabeth

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

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