Application Summary

Application Detail

License Type:	**Medical Doctor**
Application:	**To Change Any Address**
Application Date:	**04/02/2020 (mm/dd/yyyy)**

Addresses

Mailing Address

Address:	**3814 Auburn Ln** **DAVIDSON** **Nashville, TN** **37215** **US**
Phone Number:	**507-202-0916**
Extension:	
E-mail Address:	**axelgrothey@mac.com**

Practice Address

Name:	**West Clinic, P.C.**
Address:	**7759 Wolf River Blvd** **SHELBY** **Germantown, TN** **38138** **US**
Phone Number:	**901-683-0055**
Extension:	
E-mail Address:	**credentialing@westclinic.com**

Attestation

This certifies that the information submitted by me in this application is true and complete.

Application Summary

Application Detail

License Type:	**Medical Doctor**
Application:	**Updates to Mandatory Practitioner Profile Questionnaire**
Application Date:	**04/08/2020 (mm/dd/yyyy)**

Addresses

Practice Address

Name:	**West Clinic, P.C.**
Address:	**7945 Wolf River Blvd** **SHELBY** **Germantown, TN** **38138** **US**
Phone Number:	**901-683-0055**
Extension:	
E-mail Address:	**credentialing@westclinic.com**

Practice Address Questions for Clarification

Is your practice address your home address?	**No**

Medical, Professional or Training Schools

What school(s)/educational programs have you attended?	**University of Bochum**
City:	**Bochum**
State:	**Other, please specify**
If chose other, please specify:	**Germany**
Country:	**Germany**
Date attendance started at institution:	**09/01/1981 (mm/dd/yyyy)**
Date attendance ended at institution:	**11/12/1987 (mm/dd/yyyy)**

Date graduated from institution: **11/12/1987 (mm/dd/yyyy)**

What type of degree do you hold from the institution? **Doctor of Medicine**

Graduate Medical Education or other Graduate-Level Training 1

Institution you attended for medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). **University of Essen, West**

Specialty Area: **Internal Medicine**

State: **Other, please specify**

If chose other, please specify: **Germany**

Date attendance started at institution: **04/05/1988 (mm/dd/yyyy)**

Date attendance ended at institution: **11/30/1989 (mm/dd/yyyy)**

Graduate Medical Education or other Graduate-Level Training 2

Institution you attended for medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). **University of Essen**

Specialty Area: **Pathology**

State: **Other, please specify**

If chose other, please specify: **Germany**

Date attendance started at institution: **12/01/1989 (mm/dd/yyyy)**

Date attendance ended at institution: **10/31/1990 (mm/dd/yyyy)**

Graduate Medical Education or other Graduate-Level Training 3

Institution you attended for medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). **University of Bochum**

Specialty Area: **Internal Medicine**

State: **Other, please specify**

If chose other, please specify: **Germany**

Date attendance started at institution: **11/01/1990 (mm/dd/yyyy)**

Date attendance ended at institution: **06/30/1994 (mm/dd/yyyy)**

Graduate Medical Education or other Graduate-Level Training 4

Institution you attended for medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). | **University of Bochum**

Specialty Area: **Hematology/Oncology**

State: **Other, please specify**

If chose other, please specify: **Germany**

Date attendance started at institution: **07/01/1994 (mm/dd/yyyy)**

Date attendance ended at institution: **08/31/1996 (mm/dd/yyyy)**

Graduate Medical Education or other Graduate-Level Training 5

Institution you attended for medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). **MD Anderson Cancer Center**

Specialty Area: **Molecular Biology**

State: **Texas**

Date attendance started at institution: **09/01/1996 (mm/dd/yyyy)**

Date attendance ended at institution: **07/19/1998 (mm/dd/yyyy)**

Graduate Medical Education or other Graduate-Level Training 6

Institution you attended for medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). **Mayo Clinic**

Specialty Area: **Oncology**

State: **Minnesota**

Date attendance started at institution: **08/02/2003 (mm/dd/yyyy)**

Date attendance ended at institution: **07/29/2005 (mm/dd/yyyy)**

Specialty Board Certifications

Name of certifying body or board institution which issued the recognized specialty: **American Board of Internal Medicine**

Name of the recognized certification, specialty or subspecialty: **American Board of Internal Medicine**

Attestation

Date of Profile Submission: **04/08/2020 (mm/dd/yyyy)**

Final Disciplinary Action by a Licensing Board

Name of agency which issued the discipline:	**Minnesota Board of Medical Practice**
Address of the agency:	**2829 University Ave SE**
City where the agency is located:	**Minneapolis**
State where the agency is located:	**Minnesota**
Zip code were the agency is located:	**55414**
Date the disciplinary action was taken:	**03/14/2020 (mm/dd/yyyy)**
Description of Violation:	**Romantic relationship with physician colleague who was undergoing a Fellowship**
Description of Disciplinary Action:	**License reprimanded with terms; assessed costs**
Is the final disciplinary action under appeal?	**No**

Attestation

PRACTITIONER PROFILE ATTESTATION: I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-32-113 and/or 63-32-118. I understand that by submitting this profile questionnaire, I realize that I willnot receive a confirmation report before this information is published online.