Uniform Application for Physician Licensure

UA Username mcnicholasc **Date Submitted** 12/6/2013
FCVS Status Applicant has an FCVS Packet **- FCVS Packet information was not used in UA.**

1. Name: Indicate your full legal name. 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.

1. Full Name (use no initials)

Last Name McNicholas
First Name Colleen
Middle Name
Suffix
Maiden Name
M.D. ☐ **D.O.** ☒

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business
☒ **Public Access**
☒ **Mailing**

Street 4533 Clayton Ave
Box 8219
City St Louis **State/Province** MO **Zip Code** 63110
Country USA
Telephone 314-747-1331
Fax 314-747-6722
Email Confidential
Alternate Phone

Home
☐ **Public Access**
☐ **Mailing**

Street Confidential
City Crestwood **State/Province** MO **Zip Code** 63126
Country USA
Telephone Confidential
Fax
Email Confidential
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country
Confidential 1980	Chicago	Illinois	USA

Gender	Social Security Number	NPI	Are you a U.S. Citizen?
F	Confidential	1962664730	[X] 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, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1

School Name Kirksville College of Osteopathic Medicine
Address 800 West Jefferson Street
City Kirksville
State/Province MO
ZIP Code 63501
Country USA
Attendance Dates **From (mm/yyyy)** 07/2003 **To (mm/yyyy)** 06/2007
Graduation Date 6/2/2007
Degree DOM

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "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 this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "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 this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1 **Hospital Name** Atlanta Medical Center
Hospital Address 303 Parkway Drive

City Atlanta
State/Province Georgia
ZIP Code 30312
Country USA

PGY: (e.g., 1, 2, 3, etc.) [X] **Internship** [ ] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty OB/GYN

From: 07 /2007 **To:** 06 /2008 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]
Month Year Month Year

2 **Hospital Name** Washington Unniversity School of Medicine
Hospital Address 1 BArnes Jewish Plaza

City St Louis
State/Province Missouri
ZIP Code 63110
Country

PGY: (e.g., 1, 2, 3, etc.) [ ] **Internship** [X] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty OB/GYN

From: 06 /2008 **To:** 06 /2011 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]
Month Year Month Year

3 **Hospital Name** Washington University School of Medicine
Hospital Address 1 BArnes Jewish Plaza

City St Louis
State/Province Missouri
ZIP Code 63110
Country

PGY: (e.g., 1, 2, 3, etc.) [ ] **Internship** [ ] **Residency** [X] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Family Planning

From: 07 /2011 **To:** 06 /2013 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]
Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
NBOME - Comlex Level 1		06/2005	[X] P	[ ] F	1
NBOME - Comlex Level 2 CE		08/2006	[X] P	[ ] F	1
NBOME - Comlex Level 2 PE		07/2006	[X] P	[ ] F	1
NBOME - Comlex Level 3		10/2008	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	**State/Province**	GA	**Practitioner Type (MD, DO, etc.)**	DO	**Type of License (Full, Temporary, etc.)**	Training License	
	License Number	002578	**Status**	Inactive	**Issue Date**	6/1/2007	
2	**State/Province**	MO	**Practitioner Type (MD, DO, etc.)**	DO	**Type of License (Full, Temporary, etc.)**	Training License	
	License Number	2008015965	**Status**	Inactive	**Issue Date**	6/1/2008	
3	**State/Province**	MO	**Practitioner Type (MD, DO, etc.)**	DO	**Type of License (Full, Temporary, etc.)**	Full License	
	License Number	2011003938	**Status**	Active	**Issue Date**	6/1/2011	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* 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 FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2007 To: Month: 06 Year: 2008 In Progress ☐	**Practice/Employment Name** Atlanta Medical center - OB/GYN residency (or list non-working time as indicated above) **Practice/Employment Address** 303 Parkway Drive **City** Atlanta **State/Province** Georgia **ZIP Code** 30312 **Country** USA **Position and Department** OB/GYN intern-OB/GYN **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
2 From: Month: 07 Year: 2009 To: Month: 06 Year: 2011 In Progress ☐	**Practice/Employment Name** Washington University School of Medicine (or list non-working time as indicated above) **Practice/Employment Address** 1 Barnes Jewish Plaza **City** St Louis **State/Province** Missouri **ZIP Code** 63110 **Country** USA **Position and Department** OB/GYN resident-OB/GYN **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
3 From: Month: 07 Year: 2011 To: Month: 06 Year: 2013 In Progress ☐	**Practice/Employment Name** Washington University School of Medicine (or list non-working time as indicated above) **Practice/Employment Address** 1 Barnes Jewish Plaza **City** St Louis **State/Province** Missouri **ZIP Code** 63110 **Country** USA **Position and Department** Clinical Fellow-OB/GYN **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Kansas State Board of Healing Arts
Addendum 1

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Discipline applying for: (Check appropriate item)

☐ Medicine & Surgery ☒ Osteopathic Medicine & Surgery

License Designation: Please select the license designation you are requesting.

☒ Active — A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

☐ 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 South Wind Women's Center
3. Primary Specialty OB | GYN

   American Board Certified _____ American Board Eligible Exam 1/17/14

Statement of Health:

4. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your particular branch of the healing arts or your particular specialty?

   ☐ Yes ☒ No

   If yes, applicant shall file with this application, a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.

Name (Printed or typed): Colleen McNicholas Date: 12/3/13

Kansas State Board of Healing Arts
Addendum 2

Please answer each of the following questions by putting a check (✓) in the appropriate box. All "yes" answers MUST be thoroughly explained in detail in 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 that 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 particular question, check (✓) the "yes" box and submit the appropriate form if required. 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, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check (✓) the "no" box. It is your continuing duty to update the Board on any changes once the application has been submitted.

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 or educational program, including but not limited to medical school, 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

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?
☐Yes ☑No

5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?
☐Yes ☑No

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?
☐Yes ☑No

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

11. Has any professional association imposed any disciplinary action against you?
☐Yes ☑No

12. Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?
Confidential

13. Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?
Confidential

Dates: From/To	Practice/Employment
4 From: Month: 07 Year: 2013 To: Month: Year: In Progress ☒	**Practice/Employment Name** Washington University School of Medicine (or list non-working time as indicated above) **Practice/Employment Address** 4533 Calyton Ave Box 8219 **City** St Louis **State/Province** Missouri **ZIP Code** 63110 **Country** USA **Position and Department** Assistnat Professor-OB/GYN **Percent Clinical:** 75% **Percent Administrative:** 25% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

11. Malpractice: List of 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 you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Send this form to the state board you are applying to. Do not send this to FSMB.

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB.

Doing so will cause a delay with your state board application.

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.

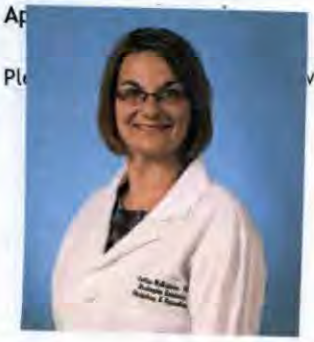
I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being 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 such a change occurs at any time prior to a license to practice medicine 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 or permit to practice medicine.



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

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McNicholas

Applicant's printed last name

Colleen P

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

12/18/13

Date of signature (must correspond to date of notarization)

Notary

State of Missouri, County of St. Louis.

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 18 day of December, 2013.

Notary Public Signature: Dana Westrich

My Notary Commission Expires: July 19, 2016

DANA WESTRICH
Notary Public - Notary Seal
STATE OF MISSOURI
Jefferson County
My Commission Expires: July 19, 2016
Commission # 12392034

ADDENDUM 3

RECEIVED
DEC 16 2013
KSBHA

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations From Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or typed): COLLEEN McNicholas Date of Birth Confidential 80

Please mail this document to the Kansas State Board of Healing Arts at the address shown above. Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. COLLEEN McNicholas (type or print) for 4 years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. Colleen McNicholas is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: David L. Eisenberg, MD, MPH
Street 1: 4533 Clayton Ave
Street 2: Box 8219
State/Zip: St. Louis, MO 63110
Telephone: 314-362-3751
Signature: [signature]
Date: 12/9/13

ADDENDUM 3

RECEIVED
DEC 13 2013
KSBHA

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations From Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or typed): COLLEEN McNICHOLAS Date of Birth Confidential 80

Please mail this document to the Kansas State Board of Healing Arts at the address shown above. Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. McNicholas, Colleen (type or print) for 7 years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. McNicholas is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Jeffery Peipert

Street 1: 4533 Clayton Ave

Street 2: Division of Clinical Research

State/Zip: St. Louis MO 63110

Telephone: 314.747.6576

Signature: [signature]

Date: 12/9/13

Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Jane A. Rackers, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
website: www.pr.mo.gov/healingarts.asp

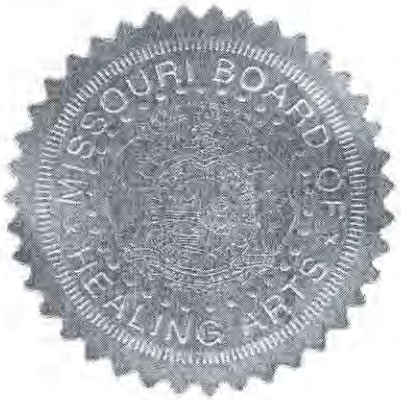
Connie Clarkston
Executive Director

To:

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

This is to certify that the records of the Missouri Board of Healing Arts indicate the following information regarding Colleen Patricia McNicholas.

LICENSE TYPE:	Osteopathy Phys/Surg Temp
DATE OF BIRTH:	Confidential 1980
LICENSE NUMBER:	2008015965
DATE ISSUED:	6/16/2008
STATUS:	Lapsed
EXPIRATION DATE:	6/30/2011
LICENSE METHOD:	
MEDICAL SCHOOL:	Kirksville Clg Of Osteopathic Med
DISCIPLINARY ACTION:	None



Chase Bonine
Verifications Clerk

12/20/2013
Date

This is the only form that will be used by the Missouri State Board of Registration for the Healing Arts for the purpose of license verification.

Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Jane A. Rackers, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
website: www.pr.mo.gov/healingarts.asp

Connie Clarkston
Executive Director

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DEC 26 2013

To:

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

This is to certify that the records of the Missouri Board of Healing Arts indicate the following information regarding Colleen Patricia McNicholas, D.O..

LICENSE TYPE:	Osteopathy Phys & Surgeon
DATE OF BIRTH:	Confidential 1980
LICENSE NUMBER:	2011003938
DATE ISSUED:	2/10/2011
STATUS:	Active
EXPIRATION DATE:	1/31/2015
LICENSE METHOD:	Natl Bd of Osteopathic Examiners
MEDICAL SCHOOL:	Kirksville Clg Of Osteopathic Med
DISCIPLINARY ACTION:	None

Chase Bonine
Verifications Clerk

12/20/2013
Date

This is the only form that will be used by the Missouri State Board of Registration for the Healing Arts for the purpose of license verification.

GEORGIA COMPOSITE MEDICAL BOARD

EXECUTIVE DIRECTOR
LaSharn Hughes

BOARD CHAIRPERSON
Richard L. Weil, MD

2 Peachtree Street, N.W., 36th Floor • Atlanta, Georgia 30303 • Tel: 404.656.3913 • Fax 404-656-9723
http://www.medicalboard.georgia.gov E-Mail: www.medbd@dch.ga.gov

FAX

ATTN:

TO Ms Anno (Kansas) FROM: GCMB

FAX 785 296 0852 PAGES: 2 w/cover

PHONE: DATE: 4/4/14

RE: CC:

O Urgent O For Review O Please Comment O Please Reply O Please Recycle

Re: Colleen McNicholas
Hard copy in the mail
Thanks

GEORGIA COMPOSITE MEDICAL BOARD

EXECUTIVE DIRECTOR
LaSharn Hughes, MBA

BOARD CHAIRPERSON
Richard Weil, M.D.

2 Peachtree St., N.W., 36th Floor • Atlanta, Georgia 30303 • Tel: 404.656.3913 • Fax 404.656.9723
http://www.medicalboard.georgia.gov E-Mail: Medbd@dch.ga.gov

Friday, April 4, 2014

RE: **Colleen McNicholas, MD**

TO WHOM IT MAY CONCERN:

This is to certify that the above has been issued a license by the Georgia Composite Medical Board.

It is further certified that:

The license number is **2578** and was issued on **June 29, 2007**

The current license status is **Lapsed**

The license expiration date is **June 30, 2008.**

Board Actions A review of public records indicates that no public board orders have been docketed.

Certified this day Friday, April 4, 2014.

Georgia Composite Medical Board

LaSharn Hughes
Executive Director

LLH/

05-37154

GEORGIA COMPOSITE MEDICAL BOARD

EXECUTIVE DIRECTOR
LaSharn Hughes, MBA

BOARD CHAIRPERSON
Richard Weil, M.D.

2 Peachtree St., N.W., 36th Floor • Atlanta, Georgia 30303 • Tel: 404.656.3913 • Fax 404.656.9723
http://www.medicalboard.georgia.gov E-Mail: Medbd@dch.ga.gov

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Georgia Composite Medical Board

LaSharn Hughes
Executive Director

LLH/

RECEIVED
DEC 23 2013

Kansas

WAIVER AGREEMENT AND STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize 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. Pursuant to K.S.A. 22-4701 *et seq.* and K.S.A. 22-5001, the Kansas State Board of Healing Arts may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the Kansas State Board of Healing Arts of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Kansas State Board of Healing Arts may choose to deny my application or grant me a limited or restricted license until the criminal history background check is completed.

I understand that, upon my request, the Kansas State Board of Healing Arts will provide me with a summary of the information contained in my Criminal History Background Report for the limited purpose of challenging the accuracy and/or completeness of the information contained in the report, but will not provide me with a complete copy of the Criminal History Background Report. I understand that I may obtain a prompt determination as to the validity of my challenge before the Kansas State Board of Healing Arts makes a final decision about my application for license to practice the healing arts. I further understand that I will not be provided access to information in my Criminal History Background Report under the following circumstances: 1) I am granted a full, unrestricted license, 2) I voluntarily withdraw an application for licensure, or 3) I am denied a license and have exhausted all my right to appeal the denial.

I have _____ OR have not X 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 3805, and may result in the denial of my application pursuant to K.S.A. 65-2836 (a).

Signature _____ Date 12/3/13

Confidential

COLLEEN McNICHOLAS _____ Date of Birth /80

Printed Name

808 Wildwood Circle Crestwood MO 63126

Residential Address City State Zip

1/24/14

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for

Name: **Colleen P McNicholas**

Social Security Number: Confidential

Date of Birth: Confidential **1980**

FID#: **213409980**

Recipient: **KS - Kansas State Board of Healing Arts**

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.

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis Report for further details on the unresolved items

Medical Professional Name: **Colleen P McNicholas**
Date of Birth: Confidential **1980**
Social Security Number: Confidential
FID: **213409980**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

Kirksville College of Osteopathic Medicine, A.T. Still University
1. Medical Education Form
2. Medical Education Dean's Letter
3. Medical Education Transcript
4. Medical Education Diploma

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

Atlanta Medical Center
1. GME Form

Washington University / Barnes Jewish Hospital
1. GME Form

Washington University School of Medicine
1. GME Form

VI. Licensure Examination History

A. NBOME Exams
B. FSMB Exams

End of report for: Colleen P McNicholas

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Table of Contents

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

Section I

FCVS Reports

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name: **Colleen P McNicholas**
Documentation: Certified Birth Certificate

Variation of Name: **Colleen Patricia McNicholas**
Documentation: Certified Birth Certificate

Gender: Female

Date of Birth: Confidential , 1980

Place of Birth: Chicago, IL, UNITED STATES

Social Security Number: Confidential

FID: 213409980

Physical Description: Height: 5 ft. 3 in.
Weight: 155 lbs.
Eye Color: Blue
Hair Color: Brown

Contact Information

Mailing Address: 4533 CLAYTON AVE # 8219
SAINT LOUIS, MO 63110-1501
UNITED STATES

Permanent Address: Confidential
SAINT LOUIS, MO 63126 Confidential
UNITED STATES

Telephone Numbers: Primary: Confidential
Secondary: N/A
Fax: N/A
Other: N/A

Pre-medical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **Illinois Benedictine College**
Address: Lisle, IL 60532
UNITED STATES
Dates of Attendance: 08/--/1998 To 05/--/2003
Degree Conferred/Issued: Bachelor of Science

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **Kirksville College of Osteopathic Medicine, A.T. Still University**
Address: 800 West Jefferson Street
Kirksville, MO 63501
UNITED STATES

Dates of Attendance: 08/20/2003 to 05/25/2007
Date Certificate Issued: 06/02/2007
Degree Conferred/Issued: Doctor of Osteopathic Medicine

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **Atlanta Medical Center**
Address: 303 Parkway Drive NE/Box 423
Atlanta, GA 30312
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/2007 To 06/30/2008
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Institution: **Washington University / Barnes Jewish Hospital**
Address: 4911 Barnes-Jewish Hospital Plaza
Campus Box 8064
St Louis, MO 63110
UNITED STATES

Training Level: 2 - 4
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/09/2008 To 06/18/2011
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Institution: **Washington University / Barnes-Jewish Hospital**
Address: 4911 Barnes-Jewish Hospital Plaza
St Louis, MO 63110
UNITED STATES

Training Level: 5 - 6
Program Type: Fellowship
Specialty: Family Planning
Dates of Attendance: 07/01/2011 To 06/30/2013
Completed Successfully: Yes
Accreditation: None of these

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Licensure Examinations

FSMB Transcript USMLE Step 1	Date: 06/2005	Passed the Exam
NBOME - National Board of Osteopathic Medical Examiners NBOME - COMLEX Level 1	Date: 06/2005	Passed the Exam
NBOME - National Board of Osteopathic Medical Examiners NBOME - COMLEX Level 2 PE	Date: 07/2006	Passed the Exam
NBOME - National Board of Osteopathic Medical Examiners NBOME - COMLEX Level 2 CE	Date: 08/2006	Passed the Exam
NBOME - National Board of Osteopathic Medical Examiners NBOME - COMLEX Level 3	Date: 10/2008	Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

A report of the results from a search of the Board Action Data Bank is enclosed.

End of report for: Colleen P McNicholas FID: 213409980

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, Post Graduate Training program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Medical Professional Identification

Medical Professional Name: **Colleen P McNicholas**
Date of Birth: Confidential **1980**
Social Security Number: Confidential
FID: **213409980**

Omissions

There are no omissions identified.

Discrepancies

There are no discrepancies identified.

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Colleen P McNicholas

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Colleen P McNicholas**
Date of Birth: Confidential **1980**
Social Security Number: Confidential
FID#: **213409980**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
07/2003	06/2007	Medical Education Record	Kirksville College of Osteopathic Medicine, A.T. Still University,800 West Jefferson Street Kirksville, MO 63501 UNITED STATES		
07/2007	06/2008	GME Record	Atlanta Medical Center,303 Parkway Drive NE/Box 423 Atlanta, GA 30312 UNITED STATES		
06/2008	06/2011	GME Record	Washington University / Barnes Jewish Hospital,4911 Barnes-Jewish Hospital Plaza St Louis, MO 63110 UNITED STATES		
06/2011	06/2013	GME Record	Washington University / Barnes-Jewish Hospital,4911 Barnes-Jewish Hospital Plaza St Louis, MO 63110 UNITED STATES		

End of report for: Colleen P McNicholas

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Section II

FSMB and Other Reports

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FPDC | FEDERATION PHYSICIAN DATA CENTER

Board Action Clearance Report

January 17, 2014

Attn:

Re: Board Action Query Dated: January 17, 2014
FSMB Batch Number: BQ2386859

The following is a report of the search results from the Board Action Data Bank as of January 17, 2014 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of January 17, 2014

Name	DOB	School	Yr/Grad	Provider ID
Colleen P McNicholas	Confidential 1980	026010	2007	295690

License History

Licensing Entity
MISSOURI

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

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Section III

Identity

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FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

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 read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" 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 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:
The physician has been instructed to sign the front of the photograph. 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.

While the FSMB will only use collected personal information for the purposes described on our website and in the FCVS application materials, the FSMB has no control over the entities to which an applicant authorizes the release of FCVS materials. Such entities may include state medical boards, state osteopathic boards, and other entities that may be subject to state and federal public information or open records laws, which might require the release of certain FCVS pack[illegible]rmation to the public upon request.

DANA WESTRICH
Notary Public - Notary Seal
STATE OF MISSOURI
Jefferson County
My Commission Expires: July 19, 2016
Commission # 12402636

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

McNILHOLAS

Applicant's Printed Last Name

10/24/13

Date of Signature (must correspond to date of notarization)

State of Missouri, County of St. Louis,
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 24 day of October, 2013.

Notary Public Signature: Dana Westrich

My Notary Commission Expires: July 19, 2016

295690 295690

213409980

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Section IV

Medical Education

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Road
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Kirksville College of Osteopathic Medicine, A.T. Still University

Address Line 1: 800 West Jefferson Street

Address Line 2: Registrar's Office

City: Kirksville **State/Province:** MO **Zip Code (Postal Code):** 63501

Country: US

If name of institution was different when this individual attended, please note this name below:
N/A

Premedical Education:
Years of education required for admission to your medical school:
Credential/degree presented by the applicant for admission to your medical school: 0/"B.S."

Enrollment and Participation: Our records indicate that McNicholas, Colleen P
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 185 weeks of medical education on the following dates: **From:** 08/20/2003 **To:** 05/25/2007
Month Day Year Month Day Year

This individual
Was awarded the degree of Doctor of Osteopathic Medicine on 06/02/2007
Month Day Year
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.
ELECTRONIC SEAL VERIFIED

Name: Elaine Wilson

Signature: *Elaine Wilson*

Title: Records Coordinator
Date of Signature: 11/05/2013 **Phone:** (660) 626-2356
Fax: (660) 626-2926 **Email:** ewilson@atsu.edu

295690 822 213409980

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? **No**

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the Interruption/extension was approved or unapproved:

From Date: **To Date:**

Personal/Family_____

Academic remediation_____

Health _____

Financial _____

Participation in joint degree Program (e.g., MD/PhD)

Participation in non-research special study

(e.g., fellowship, international experience)_____

Participation in non-degree research _____

Other:

Other:

Please Specify:

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

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

From Date: **To Date:**

Academic Probation _____

Probation for unprofessional conduct/behavioral _____

Other:

Please specify a reason:

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? **No**

If YES, please provide detailed documentation/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? **No**

If YES, please provide detailed documentation/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? **No**

If YES, please provide detailed documentation/information about the nature of the limitations or special requirement:

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Colleen P McNicholas

Kirksville College of Osteopathic Medicine, A.T. Still University

Unusual Circumstances

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

End of report for: Colleen P McNicholas

PROVIDED BY APPLICANT

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A.T. STILL UNIVERSITY | ATSU

MEDICAL STUDENT PERFORMANCE EVALUATION

For

Colleen McNicholas

IDENTIFYING INFORMATION

This evaluation is on behalf of Ms. Colleen McNicholas, a fourth year medical student at the Kirksville College of Osteopathic Medicine (KCOM).

UNIQUE CHARACTERISTICS

Ms. McNicholas completed her premedical education at Benedictine University where she received a Bachelor of Science degree in Forensic Chemistry in 2003. Special preparatory experiences for entering her medical education and training included working as a Pathology Assistant, as a Cell Biology Researcher, and as a Student Lab Technician. She distinguished herself during undergraduate school by receiving the American Chemical Society Division of Analytical Chemistry 2001 Undergraduate Award, the Gregory Snoke Memorial Scholarship, and the Senior Academic Award: College of Arts and Science. Her extracurricular activities included intramural sports.

While a student at KCOM, Ms. McNicholas has been an active member of the Student Association of Research and Diagnostic Medicine, the Student Osteopathic Medical Association, the American Medical Student Association, and the ATSU Diversity Committee. She has also served as the President of the Student Association of Research and Diagnostic Medicine, and as the Vice President of Medical Student for Choice.

ACADEMIC HISTORY

- Date of Expected Graduation: June 02, 2007
- Date of Initial Matriculation into Medical School: August 20, 2003

ACADEMIC PROGRESS

Ms. McNicholas has completed all preclinical components of the curriculum as established by the KCOM Curriculum Committee in accordance with KCOM faculty. Ms. McNicholas achieved a numerical grade point average Confidential placing her in a class rank of Confidential

Ms. McNicholas is progressing toward osteopathic medical licensure by passing the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) Level 1 with a score Confidential She is required to take COMLEX-USA Level 2 prior to graduation.

In the preclinical components of the curriculum Ms. McNicholas performed well, progressing

through her coursework without difficulty. All KCOM students participate in core rotations, which are done at KCOM regional sites. Each student is required to have completed four weeks of General Practice/Family Medicine; four weeks of Rural or Underserved Family Medicine; eight weeks of Internal Medicine; four weeks of Surgery; four weeks of Pediatrics; four weeks of OB/Gyn; four weeks of Psychiatry; two weeks of Radiology; and two weeks of Anesthesiology.

Ms. McNicholas will successfully complete the following fourth year rotations prior to graduation: four weeks of Family Medicine; eight weeks of Primary Care Electives; four weeks of Critical Care; four weeks of Emergency Medicine; four weeks of Orthopedics, Neurology, or Psychiatry; four weeks of Pediatric Elective; four weeks of Internal Medicine Elective; four weeks of Internal Medicine or Surgery Elective; and ten weeks of additional Electives.

PRECEPTOR COMMENTS

- **Pediatrics:** Colleen did an excellent job. She is good with the patients.
- **Rural Family Practice:** Colleen did a fantastic job in my office. All of my patients liked her a lot and they commented on how good she was. She is very caring, knowledgeable, and is always willing to participate.
- **Surgery:** Colleen is a mature, responsible individual who is well-motivated, and is always respectful to the staff and to the patients. Given any topic/assignment, she researches the topic and can apply the knowledge with "common sense." Her rapport with the staff is exemplary. Her care of patients comes from not only a good medical knowledge base, but as a human being, and she should be commended. It has been a pleasure having her on this rotation.
- **OB/GYN:** Colleen is motivated and is a hardworking student.
- **Internal Medicine:** Colleen is hardworking, conscientious, comprehensive, meticulous, compassionate, and pays attention to detail. She consistently shows zeal to discuss and to learn new concepts. She is an exceptionally intelligent student.
- **Psychiatry:** Colleen has good clinical knowledge and good judgment.
- **Anesthesiology:** She listens attentively, and she actively participates in administering anesthesia for several patients. She has the capability and the capacity to rationalize even the most difficult cases. Colleen has a strong knowledge of basic anesthesiology.
- **Radiology:** Colleen is a dependable student, and is willing to learn.
- **Family Practice:** Colleen is one of the best students that I have had in the fourteen years of practice! She is very friendly and knowledgeable. She makes the patients feel comfortable.

SUMMARY	
In summary, Ms. McNicholas has performed well as a medical student and at the end of her third year has completed all requirements established by the KCOM Curriculum Committee in accordance with KCOM faculty without difficulty. Ms. McNicholas is expected to graduate June 2007.	
SUBMITTED BY: **Philip C. Slocum, D.O., FCCP, FACOI, FCCM** **Professor of Medicine** **Vice President for Medical Affairs and Dean**	**Date:** September 1, 2006

A.T. Still University of Health Sciences

Kirksville College of Osteopathic Medicine

By the authority of the Board of Trustees
and upon recommendation of the faculty

Colleen P McNicholas

has been awarded the degree of

Doctor of Osteopathic Medicine

and is entitled to all rights, honors and privileges pertaining thereto
witness the seal of the university and the signatures of its officers at
Kirksville, Missouri, this second day of June, 2007.

President
EW

Stephen A. Kanter D.O.
Board of Trustees Chair
EW

Vice President for Medical Affairs & Dean
EW

Elaine Wilson
RECORDS COORDINATOR
OFFICE OF THE REGISTRAR

Section V

Graduate Medical Education

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Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Atlanta Medical Center

Attention: OBSTETRICS AND GYNECOLOGY

Specialty: Obstetrics and Gynecology

Affiliated University: _____

Address: Atlanta, GA

Verification For:

Name: McNicholas, Colleen P

Confidenti [illegible] 1980

Individual's Name on Record (If different from above): _____

Program Participation:

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: PGY1 (e.g., 1, 2, 3, etc.) **Specialty/Subspecialty:** OBGYN

☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

From: 7/01/2007 To: 6/30/2008

Successfully Completed?: ☒ Yes ☐ No ☐ In Progress

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.) **Specialty/Subspecialty:** _____

☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

From: / / To: / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.) **Specialty/Subspecialty:** _____

☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

From: / / To: / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☑ No
2. Was this individual ever placed on probation? ☐ Yes ☑ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☑ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☑ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☑ No

Please explain any "Yes" response from above:

_____

_____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this [illegible] verified

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Miriam Parker MD

Signature: [signature]

Title of Signatory: D.I.O. / GME (e.g., Program Director)

Date of Signature: 12/03/13

Tel: 404-265-3697 Fax: 404-265-1989 E-Mail: miriam.parker@tenethealth.net

Rev. 11/15/2013

FCVS ID: 205600 FID: 212400080 CODE: 100542

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name: Colleen P McNicholas
Atlanta Medical Center
Obstetrics and Gynecology

Unusual Circumstances

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

End of report for: Colleen P McNicholas

PROVIDED BY APPLICANT

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

Atlanta Medical Center
Graduate Medical Education – Department of Obstetrics and Gynecology

Intern Exit Evaluation

Resident Name: Colleen McNicholas Date: 6/3/08

Residency Dates: (Began) 7/1/07 (End) 6/7/08

Residency Satisfactorily Completed: YES NO
If No, State Reason: PGY 1 intern OB/GYN

	Satisfactory	Unsatisfactory
Patient Care	[✓]	[ ]
Medical Knowledge	[✓]	[ ]
Practice-Based Learning and Improvement	[✓]	[ ]
Interpersonal and Communication Skills	[✓]	[ ]
Professionalism	[✓]	[ ]
Systems-Based Practice	[✓]	[ ]
Technical Ability	[✓]	[ ]
Faculty-Professional Associate Evaluations	[✓]	[ ]
Operative Experience Log	[✓]	[ ]
CREOG Examination	[✓]	[ ]

✓ Resident is in compliance with RRC requirements and educational goals.

The Atlanta Medical Center Department of Obstetrics and Gynecology certifies that:

✓ Resident satisfactorily completed the requirements for the PGY-1 year.

Comments:

Colleen McNicholas
Resident Signature

6/3/08
Date

Rhonda L[illegible], M.D. /OB/GYN Program Director

6/3/08
Date

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Washington University / Barnes Jewish Hospital
Attention: **Program Director**

Specialty: Obstetrics and Gynecology
Affiliated University: _____

Address: St Louis, MO

Verification For:

Name: McNicholas, Colleen P
Confidential 1980
Individual's Name on Record (If different from above): _____

Program Participation:

Important:
Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 2,3,4 (e.g., 1, 2, 3, etc.)
☐ Internship
☒ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: Obstetrics and Gynecology
From: 6/9/2008 **To:** 6/18/2011
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: _____
From: / / **To:** / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: _____
From: / / **To:** / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

_____

_____

Certification:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Affix your institutional seal in this space. If no seal is available, you must have this verification notarized

ELECTRONIC SEAL VERIFIED

Name: Anthony L. Shanks, M.D.
Signature: Anthony L. Shanks, M.D.

Title of Signatory: Program Director, OBGYN Residency
Date of Signature: October 23, 2013

Tel: 314-362-1016 Fax: 314-747-1490 E-Mail: shanksa@wudosis.wustl.edu

Rev. 10/23/2013

FCVS ID: 295690 FID: 213409980 CODE: 116344

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name: Colleen P McNicholas
Washington University / Barnes Jewish Hospital
Obstetrics and Gynecology

Unusual Circumstances

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

End of report for: Colleen P McNicholas

PROVIDED BY APPLICANT

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

Washington University in St. Louis

SCHOOL OF MEDICINE

Department of Obstetrics and Gynecology

SUMMATIVE EVALUATION

Program: Obstetrics and Gynecology **Resident Name:** Colleen P. McNicholas, D.O.
Residency Dates: June 13, 2008 to June 18, 2011
Evaluation encompasses final evaluation time frame: 4 Years of Residency

This evaluation is based on demonstrated performance compared to what is reasonably expected of the practitioner at his/her level of training, experience, and background.

	Successful	Unsuccessful
Medical Knowledge	X	
Patient Care	X	
Practice Based Learning and Improvement	X	
System Based Practice	X	
Interpersonal and Communication Skills	X	
Professionalism	X	

CORRECTIVE ACTION:
During the period verified above, was the practitioner ever subject to any disciplinary action, such as: admonition, reprimand, suspension or termination? Yes_____ No X
If yes, details are described on a separate sheet of paper and attached to this form.

EVALUATION:
Highly competent/without reservation X
Some reservations_____
Qualified and competent_____
See attached letter_____

Evaluation based on:
Close Personal Observation X
General Impression_____

ADDITIONAL COMMENTS:

Colleen P. McNicholas, D.O. satisfactorily completed her residency in OBGYN on June 18, 2011. In reviewing her evaluations and performance during the residency including the Chief Resident year, Dr. Colleen P. McNicholas has acquired the skills and knowledge necessary for her to practice Obstetrics and Gynecology both competently and independently. Dr. Colleen P. McNicholas has demonstrated sufficient competence to enter practice without supervision.

Signature _____ **Date** 6/27/11

Name (Print or Type) Jeffrey F. Peipert, M.D. **Title** Program Director, OBGYN Residency

RELEASE OF INFORMATION:
I hereby release Washington University School of Medicine/Barnes-Jewish Hospital, its employees and medical staff from all liability in release of this information to all persons including hospitals, medical staffs, schools, professional societies, associations and insurance companies. A copy of this document is as binding as original.

Signature _____ **Date** 6/17/11

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Washington University School of Medicine

Attention: **Program Director**

Specialty: Family Planning

Affiliated University: _____

Address: St Louis, MO

Verification For:

Name: McNicholas, Colleen P

Confidential 1980

Individual's Name on Record (If different from above): _____

Program Participation:

Important:

Report incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: PGY5+6 (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☑ Fellowship ☐ Research

Specialty/Subspecialty: OB/Gyn - Family Planning

From: 7/1/2011 To: 6/30/2013

Successfully Completed?: ☑ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☑ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: _____

From: / / To: / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: _____

From: / / To: / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☑ No
2. Was this individual ever placed on probation? ☐ Yes ☑ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☑ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☑ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☑ No

Please explain any "Yes" response from above:

_____

_____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this notarized

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Jeffrey F Peipert, MD, PhD

Signature: Jeffrey F Peipert

Title of Signatory: Fellowship Co Director (e.g., Program Director)

Date of Signature: 12/23/13

Tel: 314-747-4016 Fax 314-747-4019

E-Mail: Peipertj@wustl.edu

Rev. 12/12/2013

FCVS ID: 295690 FID: 213409980 CODE: 118394

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name: Colleen P McNicholas
Washington University / Barnes-Jewish Hospital
Family Planning

Unusual Circumstances

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

End of report for: Colleen P McNicholas

PROVIDED BY APPLICANT

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

Section VI

Licensure Examination History

(State Licensing Authorities Only)

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION-USA

Official Transcript

Federation Credentials Verification Svcs
Federation Place
400 Fuller Wiser Rd., Ste. 300
Euless, TX 76039-3855

Examinee: McNicholas, Colleen Patricia

NBOME ID: 744883 **Date of Birth:** Confide ntial 1980

EXAMINATION	DATE COMPLETED	PASS / FAIL	3 - DIGIT STANDARD SCORE	3 - DIGIT MINIMUM PASSING	2 - DIGIT STANDARD SCORE	2 - DIGIT MINIMUM PASSING	NOTE
Level 1							
	7-Jun-2005	Pass	Confidential				
Level 2 Cognitive Evaluation (CE)							
	15-Aug-2006	Pass					
Level 2 Performance Evaluation (PE)							
	25-Jul-2006	Pass					
Level 3							
	29-Oct-2008	Pass					

The National Board of Osteopathic Medical Examiners, Inc., does hereby certify the above to be a true report of the examinee.

Date Prepared: January 14, 2014

1105873110709910

-- please see reverse for information and description of notes -- v2.0

National Board of Osteopathic Medical Examiners, Inc.
8765 West Higgins Road Suite 200 Chicago IL 60631-4174
Phone: 773/714-0622 Fax: 773/714-0631

295690