APD 9209

COLORADO STATE BOARD OF MEDICAL EXAMINERS

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE FEE $425.00

READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS APPLICATION. ALL QUESTIONS ON THIS APPLICATION MUST BE ANSWERED, AND ALL SUPPORTING DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION PER INSTRUCTIONS. THE ENCLOSED CHECKLIST IS PROVIDED FOR YOUR CONVENIENCE. PLEASE TYPE OR PRINT NEATLY. WHEN SPACE PROVIDED IS INSUFFICIENT, ATTACH ADDITIONAL SHEETS OF PAPER. YOU MAY REPRODUCE THESE BLANK FORMS AS NEEDED, BUT EACH COMPLETED FORM YOU SUBMIT MUST BE IN ORIGINAL INK OR TYPE. **MAKE SUFFICIENT COPIES OF ALL FORMS BEFORE YOU BEGIN.**

1 a. Name: Last	First	Middle	Degree	1b. Social Security Number
Bowers	Marci	L	MD	

2. Other names (i.e. maiden name)- indicate if none.

None

3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE: Address provided is, by law, public information.)

☑ Home ☐ Business 8649 Fauntleroy Way SW

City	State	Zip	Country
Seattle	WA	98126	USA

e-mail address:

4. Telephone Number: (Area Code) Day	Evening	5. Date of Birth: Mo/Day/Year	Place of Birth
(206) 932-7651	(206) 940-4484		Oak Park, Il.

6. Sex: Male (Female)

7. Have you ever filed an application in Colorado? ☐ Yes ☑ No If yes, give date of previous application

8. List name/address of the school where medical degree was received.
Request an original L2 Form (Certificate of Medical Education – Certificate must be sent directly from the school to this office.)

Name of School	Address and Zip	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
~~University of Minnesota (MS)~~ Univ. of Minnesota Medical School	200 Oak St. SE / Minneapolis, MN 55455	09/82	06/86 ✓

9. List name of licensing exam(s): ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam. Request certification of scores from examining agency be sent directly to this office.

Exam	Location	Date	Result
✓ NBME I, II, III		1985-86	

10. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs?
☑ Yes If yes, provide information below. ☐ No

Name of facility	Specialty	Period of attendance From (Mo/Yr)	To (Mo/Yr)
University of Washington	Ob/Gyn	7/86	6/90 ✓

Official Use Only	License # 41164	Date 12-19-02
Revised 10/99	Fee $ 425	Date: 10-22-02

COLORADO STATE BOARD OF MEDICAL EXAMINERS

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE **FEE $425.00**

READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS APPLICATION. ALL QUESTIONS ON THIS APPLICATION MUST BE ANSWERED, AND ALL SUPPORTING DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION PER INSTRUCTIONS. THE ENCLOSED CHECKLIST IS PROVIDED FOR YOUR CONVENIENCE. PLEASE TYPE OR PRINT NEATLY. WHEN SPACE PROVIDED IS INSUFFICIENT, ATTACH ADDITIONAL SHEETS OF PAPER. YOU MAY REPRODUCE THESE BLANK FORMS AS NEEDED, BUT EACH COMPLETED FORM YOU SUBMIT MUST BE IN ORIGINAL INK OR TYPE. **MAKE SUFFICIENT COPIES OF ALL FORMS BEFORE YOU BEGIN.**

1 a. Name: Last	First	Middle	Degree	1b. Social Security Number
Bowers	Marci	L	MD	

2. Other names (i.e. maiden name)- indicate if none.

None

3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE, Address provided is, by law, public information.)

☑ Home 8649 Fauntleroy Way SW
☐ Business

City	State	Zip	Country
Seattle	WA	98136	USA

e-mail address:

4. Telephone Number: (Area Code) (Day) (Evening)

(206) 932-7651 (206) 940-4484

5. Date of Birth: Mo/Day/Year Place of Birth: Oak Park, Il.

6. Sex: Male (Female)

7. Have you ever filed an application in Colorado?
☐ Yes If yes, give date of previous application
☑ No

8. List name/address of the school where medical degree was received.
Request an original L2 Form (Certificate of Medical Education – Certificate must be sent directly from the school to this office.)

Name of School	Address and Zip	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
~~Univ. of Minnesota (MS)~~			
Univ. of Minnesota Medical School	200 Oak St. SE / Minneapolis, MN 55455	09/82	06/86

9. List name of licensing exam(s): ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam.
Request certification of scores from examining agency be sent directly to this office.

Exam	Location	Date	Result
NBME I, II, III		1985-86	

10. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs?
☐ Yes If yes, provide information below.
☑ No

Name of facility	Specialty	Period of attendance From (Mo/Yr)	Period of attendance To (Mo/Yr)

L1A

Official Use Only	License #	Date
Revised 10/99	Fee $ 425	Date: 10-22-02

17. Have you ever had staff privileges at a hospital limited or reduced, denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action?

☐ **Yes** If yes, explain on a separate sheet, provide copy of resignation letter or hospital action and summarize below:

☑ **No**

Name of facility	Date	Reason for action

18. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law? Note: You must respond "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.

☐ **Yes** If yes, explain on a separate sheet. Summarize details below:

☑ **No**

Date	Court	Violation	Penalty or disposition

19. Within the last five years, have you engaged in any behavior or suffered any mental, physical or cognitive health condition that has affected or might affect your ability to practice medicine safely and competently?

Yes If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of behavior or condition involved, and what if anything has been done to correct the behavior or condition.

No

20. Within the last five years, have you illegally or excessively used any controlled substance, habit-forming drug, prescription medication, or alcohol?

Yes If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of behavior involved, and what if anything has been done to correct the behavior.

No

21. Within the last five years, have you been diagnosed or treated for bipolar disorder, severe major depression, schizophrenia or other psychotic disorder?

Yes If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of disorder involved, and what if anything has been done to treat the disorder.

No

22. Within the last five years, has any final judgment, settlement or arbitration award for medical malpractice been paid on your behalf or has any claim been filed which is still pending?

☑ **Yes** If yes, list below and complete the enclosed Claims Information Form.

☑ **No**

Date	Name and address of Insurance Company	Reason for Action
12/10/1997	Washington State Physicians Insurance	Bowel stricture after exploration (see explanation)

23. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been canceled or rated at a higher premium due to past claims experience?

☐ **Yes,** If yes, explain on a separate sheet and provide verification from insurance company or state licensing board.

☑ **No**

24. You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado Law, or claim one of the four exemptions set forth in the enclosed insurance memo. See instructions in application packet, and include proof of insurance (obtained from your insurance carrier) or include a statement setting forth the basis for the exemption claimed below.

EXEMPTION CLAIMED: _____

NOTE: ALL ITEMS IN THIS APPLICATION ARE MANDATORY; NONE ARE VOLUNTARY. FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE. The information provided will be used to determine qualification for licensure, per Section 12-36-107 and Section 12-36-111, C.R.S., which authorize the collection of this information. Applicants have the right to review their application subject to the provisions of the Colorado Open Records Act. The Program Administrator of the Colorado State Board of Medical Examiners is the custodian of records.

I, Marci L. Bowers hereby make application for a license to practice medicine in the State of Colorado. In so doing, I authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associations (past and present), and all government agencies (local, state, federal and foreign) to release to the Colorado State Board of Medical Examiners or its successors any information, files or records requested by the Board relative to my qualifications as a physician and my eligibility for licensure.

In accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law.

I state under penalty of perjury, as defined in 18-8-503, C.R.S., that the information contained this application is true and correct to the best of my knowledge.

I understand that under the Colorado Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license and that application fees are not refundable.

Marci L. Bowers MD
Signature

19 October 2002
Date

RETURN THIS APPLICATION TO:

COLORADO BOARD OF MEDICAL EXAMINERS
1560 BROADWAY, SUITE 1300
DENVER CO 80202-5140

L1D

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5146
(303) 894-7716/894-7715
FAX (303) 894-7692
V/TDD (303)894-7880
http://www.dora.state.co.us/medical

Department of Regulatory Agencies
Division of Registrations

REPORT OF PRACTICE HISTORY

	Facility Name	Address and Zip	Reference (name and title)	Dates of Practice From-To	Nature of Practice
1.	Polyclinic	1145 Broadway Seattle, WA 98122	Lloyd David Administrator	10/90	12/2001
2.	Seattle Reproductive Healthcare	1001 Broadway Suite #209 Seattle, WA 98122	Glenn Bodlow Administrator	1/2002	Present
3.	University of Washington	1959 Pacific Av. NE Seattle, WA	Morton Stenchever MD Chairman	6/86-7/90	OB/GYN Residency
4.					
5.					
6.					
7.					
8.					
9.					
10.					

PLEASE BE AWARE THAT IN COLORADO SUPPLYING FALSE INFORMATION IN AN APPLICATION FOR A LICENSE IS PUNISHABLE BY LAW.

I state under penalty of perjury in the second degree, as defined in 18-8-503, Colorado Revised Statutes, that the information contained in this application is true and correct to the best of my knowledge. I understand that under the Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

Marci L. Bowers MD — Marci Bowers — 10/19/02 — L6

SIGNATURE — PRINT LAST NAME — DATE

INSTRUCTIONS FOR COMPLETION OF THE REPORT OF PRACTICE HISTORY (L6)

1. LIST ALL OF YOUR EXPERIENCE IN MEDICAL PRACTICE IN CHRONOLOGICAL ORDER SINCE MEDICAL SCHOOL, including

- All internships, residency and fellowship programs,
- Clinic practice,
- Private practice,
- Any other medical practice or position,
- Any hospital that you held privileges at during the last five years, including temporary privileges and consulting privileges,
- Any locum tenens positions, and
- Breaks in the practice of medicine of one month or greater.

2. REQUEST AN ORIGINAL LETTER OF VERIFICATION COVERING THE LAST FIVE YEARS FOR THE ABOVE.

Each letter should be addressed to "Licensing Section, Colorado Board of Medical Examiners."

Each letter verifying hospital privileges should be written by the chief of staff or chief administrative officer.

Each letter verifying private practice, should be written by an associate or colleague.

If contracted by a locum tenens agency, one letter from that agency verifying all positions held will suffice.

Each letter must verify dates of practice (including beginning month and year and ending month and year), nature of practice, and privilege status.

Each letter must also include an evaluation of your skill level, aptitude, ability to apply knowledge, and an assessment of your attitude and behavior toward your colleagues and patients.

For Training Program: *Form L3 must be used to verify the first year of internship/post* graduate training, however, a letter or Form L3 may be used to verify training programs after the first year.

Note: If you have not practiced medicine for more than two years immediately preceding the filing of this application, refer to the Continued Competency Rule included in this package.

COLORADO BOARD OF MEDICAL EXAMINERS

CLAIMS INFORMATION FORM

The applicant must complete this form for each liability or malpractice claim which has been identified pursuant to question 22 on the application. (Form L1C)

Marci L. Bowers — (206) 328-3200

Name of Physician — **Business Telephone No.**

1001 Broadway — Seattle, WA 98122

Address — **City, State, and Zip Code**

1. **On a separate sheet of paper type your full name and provide a clinical narrative regarding each malpractice case(s)/allegations. Include name of patient, age, sex, date of occurrence, and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description which includes all of the facts requested above. Simply stating that the charges were dismissed is inadequate, more detail must be provided.**

2. **Indicate your position in case, i.e., intern, resident, primary doctor, etc.** Primary M.D.

3. **Case was filed against:** Individual doctor ☑ Group ☐ Hospital ☐
   List names of other doctors and/or hospitals also named in the suit _____

4. **Plaintiff's Attorney & Telephone** _____

5. **Is the claim pending?** YES ☐ NO ☑

6. **Was there a judgment or settlement?** YES ☑ NO ☑

7. **What was the amount and date of the judgment or settlement?** $178,000 / 12/97 $178,000

8. **What amount was attributable to you, your insurance company or your employer?** All to insurance co.

I certify that the information which I have provided is correct to the best of my knowledge.

Marci L. Bowers MD — 10/19/02

Signature — **Date**

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE CLERK OFFICE

In the Matter of the License to Practice as a Physician and Surgeon of: **MARCI LEE BOWERS, M.D.,** License No.: MD00027147	Docket No. 99-04-A-1055MD DECLARATION OF SERVICE BY MAIL

I declare under penalty of perjury under the laws of the state of Washington that the following is true and correct:

On July 13, 1999, I served a true and correct copy of the Stipulation to Informal Disposition dated July 8, 1999, by placing same in the U.S. mail by 4:30 p.m, postage prepaid, on the following parties to this case:

MARCI LEE BOWERS
C/O THE POLYCLINIC
1145 BROADWAY
SEATTLE, WA 98122-4299

DATED: This 13 day of July 1999, at Olympia, Washington.

Pam L. Mena, Adjudicative Clerk Office

cc: Maryella Jansen, Program Manager
Marcia G. Stickler, Staff Attorney

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of	)	**Docket No. 99-04-A-1055MD**
MARCI LEE BOWERS, M.D., License No.27147	)	STIPULATION TO INFORMAL DISPOSITION
Respondent.	)	

Section 1: STIPULATION

The parties to the above-entitled matter stipulate as follows:

1.1 Marci Lee Bowers, M.D., Respondent, is informed and understands that the Program Manager, on designation by the Commission, has made the following allegations:

1.1.1 In the course of bilateral salpingo-oophorectomy surgery on the patient (previously identified on a confidential schedule) on or about August 6, 1997, the Respondent negligently sutured a minute portion of small bowel while closing the fascial layer of the wound, resulting in peritonitis.

1.1.2 Despite the patient demonstrating possible complications post-operatively, the Respondent did not respond in a timely manner. A general surgeon reoperated on the patient on the ninth post-operative day.

1.1.3 The patient required further surgery and suffered a delayed recovery as a result of the complication.

1.2 Respondent is informed and understands that the Commission has alleged that the conduct described above, if proven, would constitute a violation of RCW 18.130.180 (4).

1.3 The parties wish to resolve this matter by means of a Stipulation to Informal Disposition pursuant to RCW 18.130.172(1).

1.4 Respondent agrees to be bound by the terms and conditions of the Stipulation to Informal Disposition.

1.5 This Stipulation to Informal Disposition is of no force and effect and is not binding on the parties unless and until this Stipulation to Informal Disposition is accepted by the Commission.

1.6 Respondent does not admit any of the allegations in the Statement of Allegations and Summary of Evidence or in paragraph 1.1 above. This Stipulation to Informal Disposition shall not be construed as a finding of unprofessional conduct or inability to practice.

1.7 This Stipulation to Informal Disposition is not formal disciplinary action. It is not subject to the reporting requirements of RCW 18.130.110 or any interstate/national reporting requirement.

1.8 This Stipulation to Informal Disposition is releasable to the public upon request pursuant to the Public Records Act, chapter 42.17 RCW. The Statement of Allegations and Summary of Evidence and the Stipulation to Informal Disposition shall remain part of Respondent's file and cannot be expunged.

1.9 The Commission agrees to forego further disciplinary proceedings concerning the allegations contained in sections 1.1 and 1.2 above.

1.10 Respondent agrees to successfully complete the terms and conditions of this informal disposition.

1.11 Respondent is advised and understands that a violation of the provisions of section 2 of this Stipulation to Informal Disposition, if proved, would constitute grounds for discipline under

parties unless and until this Stipulation to Informal Disposition is accepted by the Commission.

1.12 This Stipulation to Informal Disposition is not formal disciplinary action, is not intended and should not be construed as an action which "revokes or suspends (or otherwise restricts) a physician's license or censures or reprimands, or places on probation" as those words are used in Sec. 422 of the Health Care Quality Improvement Act of 1986, 42 USC 11132 and is therefore not subject to any reporting requirements to the National Practitioner Data Bank, or under RCW 18.130.110 or any interstate/national reporting requirement.

1.13 Respondent is advised and understands that a violation of the provisions of section 2 of this Stipulation to Informal Disposition, if proved, would constitute grounds for discipline under RCW 18.130.180 and the imposition of sanctions under RCW 18.130.160.

Section 2: INFORMAL DISPOSITION

Pursuant to RCW 18.130.172 (2) and based upon the foregoing stipulation, the parties agree to the following Informal Disposition. The Respondent's license to practice medicine is subject to the following terms and conditions for a period of TWO YEARS. After two years and upon successful completion of the requirements in this section, the terms and conditions herein shall automatically expire.

2.1 Respondent shall submit a plan of continuing medical education (CME) in the area of general surgical complications and post-operative care to the Commission's designee for approval. The exact number of hours and the specific content of the course or courses constituting such program shall be determined by the Commission's designee and shall total not

less than TWELVE (12) credit hours of Category I continuing medical education as described in WAC 246-917-170. This program shall be in addition to the Continuing Education requirement for relicensure. Questions concerning the specific course or courses shall be directed to the Commission's designee. Such CME plan shall be approved by the Medical Consultant, implemented and completed within ONE YEAR (1) of the effective date of this Informal Disposition.

2.2 The Respondent shall see to it that all care delivered to her patients falls within acceptable standards of medical practice. The Respondent shall obey all federal, state, and local laws and all administrative rules governing the practice of medicine in Washington.

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I, Marci Lee Bowers, M.D., Respondent, certify that I have read this Stipulation to Informal Disposition in its entirety; that my counsel of record, if any, has fully explained the legal significance and consequence of it; that I fully understand and agree to all of it; and that it may be presented to the Commission without my appearance. If the Commission accepts the Stipulation to Informal Disposition, I understand that I will receive a signed copy.

Marci L. Bowers MD

Marci Lee Bowers, M.D.
Respondent

6/30/95

Date

Section 3: ACCEPTANCE

The Commission accepts this Stipulation to Informal Disposition. All parties shall be bound by its terms and conditions.

DATED this 8th day of July, 1999.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

Janice M. Payson MD
Panel Chair

Presented by:

Marcia G. Stickler
Marcia G. Stickler, WSBA # 20712
Department of Health Staff Attorney

July 7, 1999
Date

FOR INTERNAL USE ONLY. INTERNAL TRACKING NUMBERS:

Program No. 98-12-0051MD

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 SE Quince St • P.O. Box 47866 • Olympia, Washington 98504-7866

November 13, 2002

MARCI LEE BOWERS, MD
1001 BROADWAY #207
SEATTLE WA 98122

Case No: 98-12-0051MD

Dear Dr. Bowers:

This letter is to officially inform you that the Medical Quality Assurance Commission has released you from the requirements of the *Stipulation to Informal Disposition* signed on July 8, 1999. You have demonstrated satisfactory compliance with the terms and conditions of the agreement. This letter serves to inform you and other interested parties that you are now released from the aforementioned Stipulation to Informal Disposition effective upon receipt of this letter.

The Commission wishes you well in the future.

If you have any questions concerning this matter, please feel free to contact Dirk Gillespie, Compliance Officer, at (360) 236-4794 or write to the Medical Quality Assurance Commission, P.O. Box 47866, Olympia, WA 98504-7866.

Sincerely,

Disciplinary Program Manager
Medical Quality Assurance Commission

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

DCN: 5500000027515082
Process Date: 10/20/2002

RESPONSE TO INFORMATION DISCLOSURE REQUEST

A. REQUESTOR IDENTIFICATION

Requestor Name: BOWERS, MARCI LEE
Telephone: (206)940-4484
Address: SEATTLE REPRODUCTIVE HEALTHCARE
1001 BROADWAY SUITE #207
8649 FAUNTLEROY WAY SW
City, State, ZIP: SEATTLE, WA 98122
Country:

B. PAYMENT INFORMATION

Account Number: XXXXXXXXXXXX0042
Expiration Date: 12/2004
Transaction Date: 10/20/2002
Transaction Number: 5500000027515082
Total Charge: **$ 10.00**

C. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: BOWERS, MARCI LEE
Gender: FEMALE
Date of Birth:
Other Name(s) Used:
Organization Name: SEATTLE REPRODUCTIVE HEALTHCARE
Organization Type: MEDICAL GROUP/PRACTICE (365)
Other, as Specified:
Home or Work Address: 1001 BROADWAY SUITE #207
8649 FAUNTLEROY WAY SW
City, State, ZIP: SEATTLE, WA 98122
Country:

Social Security Numbers (SSN):

Professional School(s) & Year(s) of Graduation: UNIV OF MINNESOTA MEDICAL SCHOOL 1986

Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Numbers, State of Licensure: WA00027147, WA
Other, as Specified:
Specialty: OBSTETRICS & GYNECOLOGY (50)

Drug Enforcement Administration (DEA) Numbers: BB0630473

National Provider Identifiers (NPI): 912160399

Federal Employer Identification Numbers (FEIN):

CONFIDENTIAL DOCUMENT – FOR AUTHORIZED USE ONLY

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

Unique Physician Identification Numbers (UPIN): E72307

D. SEARCH RESULT

Based on the subject identification information provided by you in Section C above, a search of the NPDB has located the following 3 report(s).

Type of Report	Report Number
Medical Malpractice Payment Report	5500000023215401
Medical Malpractice Payment Report	5500000023215421
Medical Malpractice Payment Report	5500000023215471

Recipients should verify that the subject identified in Section C is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the NPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

C. INFORMATION REPORTED

Date of Report:	10/24/2001
Act/Omission Code:	SURGERY: NOT OTHERWISE CLASSIFIED (290)
Date of Act/Omission:	08/13/1997
Payment Date:	12/16/1998
Multiple or Single Payment:	SINGLE
Amount of This Payment:	$172,616.74
Total Amount of Judgment or Settlement:	$172,616.74
Payment Result of:	SETTLEMENT
Number of Practitioners for Whom Payment Is Made:	1
Relationship of Entity to the Practitioner:	INSURANCE COMPANY
Date of Judgment/Settlement:	12/10/1998
Adjudicative Case Number:	
Adjudicative Body Name:	
Court File Number:	

Reporter's Description of the Act or Omission: 50 YO FEMALE REQUIRED BSO TO INVESTIGATE A SYMPTOMATIC OVARIAN MASS. AN INADVERTANT MICROPERFORATION OF THE SMALL BOWEL WAS DISCOVERED POST OPERATIVELY WHICH REQUIRED ADDITIONAL SURGERY AND REHABILITATION.

Reporter's Description of the Judgment or Settlement: SINGLE PAYMENT $172,616.74 FILE #11617

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, the unedited statement appears in this section.

E. REPORT STATUS

An "X" indicates that the information in this report has been

☐ Disputed by the subject identified in Section B.

☐ Elevated for decision by the Secretary of the U.S. Department of Health and Human Services -- Pending.

☐ Reviewed by the Secretary of the U.S. Department of Health and Human Services, who has made the following comment concerning the report:

Date of Initial Report: 12/29/1998

Date of Most Recent Change: 10/24/2001

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

C. INFORMATION REPORTED

Date of Report:	10/24/2001
Act/Omission Code:	SURGERY: IMPROPER PERFORMANCE OF SURGERY (250)
Date of Act/Omission:	12/30/1991
Payment Date:	08/01/1997
Multiple or Single Payment:	SINGLE
Amount of This Payment:	$40,000.00
Total Amount of Judgment or Settlement:	$40,000.00
Payment Result of:	
Number of Practitioners for Whom Payment Is Made:	1
Relationship of Entity to the Practitioner:	INSURANCE COMPANY
Date of Judgment/Settlement:	
Adjudicative Case Number:	
Adjudicative Body Name:	
Court File Number:	

Reporter's Description of the Act or Omission: ALLEGED IMPROPER SURGERY RESULTING IN VAGINAL STENOSIS IN A 55-YR-OLD MARRIED FEMALE.

Reporter's Description of the Judgment or Settlement: LUMP SUM #9475

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, the unedited statement appears in this section.

E. REPORT STATUS

An "X" indicates that the information in this report has been

☐ Disputed by the subject identified in Section B.

☐ Elevated for decision by the Secretary of the U.S. Department of Health and Human Services -- Pending.

☐ *Reviewed by the Secretary of the U.S. Department of Health and* Human Services, who has made the following comment concerning the report:

Date of Initial Report: 09/11/1997

Date of Most Recent Change: 10/24/2001

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

For authorized use by:
SELF-QUERIER

C. INFORMATION REPORTED

Date of Report:	10/24/2001
Act/Omission Code:	SURGERY: NOT OTHERWISE CLASSIFIED (290)
Date of Act/Omission:	08/16/1994
Payment Date:	03/19/1997
Multiple or Single Payment:	SINGLE
Amount of This Payment:	$100,000.00
Total Amount of Judgment or Settlement:	$100,000.00
Payment Result of:	SETTLEMENT
Number of Practitioners for Whom Payment Is Made:	1
Relationship of Entity to the Practitioner:	INSURANCE COMPANY
Date of Judgment/Settlement:	03/11/1997
Adjudicative Case Number:	95-2-141544
Adjudicative Body Name:	KING COUNTY SUPERIOR COURT, STATE OF WA
Court File Number:	
Reporter's Description of the Act or Omission:	28 YO FEMALE WITH CHRONIC PELVIC PAIN AND ADHESIONS DESIRED LAPAROSCOPIC LYSIS OF ADHESIONS. A BOWEL PERFORATION RESULTED REQUIRING SURGERY.
Reporter's Description of the Judgment or Settlement:	$100,000 SINGLE PAYMENT FILE #8563

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, the unedited statement appears in this section.

E. REPORT STATUS

An "X" indicates that the information in this report has been

☐ Disputed by the subject identified in Section B.

☐ Elevated for decision by the Secretary of the U.S. Department of Health and Human Services -- Pending.

☐ Reviewed by the Secretary of the U.S. Department of Health and Human Services, who has made the following comment concerning the report:

Date of Initial Report: 03/26/1997

Date of Most Recent Change: 10/24/2001

REC'D NOV 18 2002

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5146
(303) 894-7715/894-7716
FAX (303) 894-7692
V/TDD (303)894-7880
http://www.dora.state.co.us/medical

DEC -4 2002

BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

CERTIFICATE OF MEDICAL EDUCATION

THIS SECTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO SCHOOL WHERE MEDICAL DEGREE WAS RECEIVED

This certifies that Marci L. Bowers
FULL NAME OF APPLICANT

enrolled in University of Minnesota Medical School
FULL NAME OF MEDICAL SCHOOL

Minneapolis, Minnesota on the _____ day of September 1982
LOCATION OF MEDICAL SCHOOL

THIS SECTION TO BE COMPLETED BY PRESIDENT/SECRETARY/DEAN OF MEDICAL SCHOOL AND FORWARDED TO COLORADO BOARD OF MEDICAL EXAMINERS. COMPLETE ALL BLANKS IN THE SECTION OR FORM WILL BE RETURNED.

The undersigned certifies that the records of this institution show that he/she attended this institution beginning on the 7th day of September 1982 and was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 14th day of June, 1986.

Signed and the college seal affixed

This 2nd day of December, 2002

By Helene M. Horwitz
Helene M. Horwitz, Ph.D. Associate Dean Student Affairs

NOT VALID WITHOUT SCHOOL SEAL
NOTE TO REGISTRAR:
IF NO SCHOOL SEAL, PLEASE INDICATE ABOVE, NEXT TO SIGNATURE OF PRESIDENT/SECRETARY/DEAN.

L2

FAX to 303.894.7692

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
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Denver, Colorado 80202-5146
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Department of Regulatory Agencies
Division of Registrations

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

THIS SECTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO THE FACILITY WHERE POSTGRADUATE TRAINING WAS RECEIVED AND/OR COMPLETED

This certifies that Marci L. Bowers
FULL NAME OF APPLICANT

a graduate of University of Washington / Department of Obstetrics / Gynecology
FULL NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in Obstetrics and Gynecology, Univ. Washington, Seattle, WA 98195
NAME AND ADDRESS OF FACILITY

TO BE COMPLETED BY THE PROGRAM DIRECTOR OF THE FACILITY FOR ACGME/AOA POSTGRADUATE TRAINING IN THE UNITED STATE OR CANADA. PLEASE TYPE OR PRINT.

on June 25, 1986 and satisfactorily completed such training on June 30, 1990

This training consisted of 48 months of actual clinical instruction and is approved by the Accredited Council for Graduate Medical Education (ACGME), the American Osteopathic association (AOA), or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

List type and length of training.

ROTATION accredited Ob-Gyn residency — LENGTH OF ROTATION four years

WAS THIS PHYSICIAN'S PERFORMANCE COMPLETELY SATISFACTORY? PLEASE CHECK ONE

YES ✓ NO

IF NO, PLEASE ATTACH AN EXPLANATION.

I hereby declare under penalty of perjury under the laws of the State of Colorado that the above statements are true and correct and the facility is approved by the ACGME/AOA or the CCME to offer the type of level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

PROGRAM DIRECTOR Louis A. Vontver, MD, MEd

ADDRESS Univ. Washington OBGyn, BOX 356460

PHONE NUMBER 206 543 3891 DATE 12.2.2002

SIGNATURE Louis A. Vontver

L3

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 SE Quince St • P.O. Box 47866 • Olympia, Washington 98504-7866

December 4, 2002

RECEIVED

DEC -9 2002

BOARD OF MED EXAMINERS

STATE OF COLORADO

Colorado Board of Medical Examiners
Attn Jan Seewald
1560 Broadway Suite 1500
Denver CO 80202

To Whom It May Concern:

I, Betty Elliott, Program Representative, do hereby certify that a standard search of the available records of the Medical Quality Assurance Commission indicates the following:

PHYSICIANS NAME	**Marci Bowers, MD**
LICENSE NUMBER:	**MD00027147**
ISSUE DATE:	**03-05-1990**
EXPIRATION DATE	**01-18-2004**
DATE OF BIRTH:	**01-18-1958**

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED

If our records above show that the licensee has been disciplined, photocopies from the public file are available upon written request. Send request to the Medical Quality Assurance Commission, Public Disclosure Desk, PO Box 47866, Olympia, WA 98504-7866

The information above is the only certification information by the Commission. To expedite the certification process, the above format is the standard format prepared for all professions regulated by this Commission.

If you have any questions or need additional information, please contact me by telephone at (360) 236-4785, by email at betty.elliott@doh.wa.gov, or in writing at Department of Health, Medical Quality Assurance Commission, PO Box 47866, Olympia, Washington 98504-7866.

Sincerely,

(SEAL)

B Elliott

Betty Elliott
Licensing Representative

UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

Department of Obstetrics & Gynecology
BB-667 Health Sciences Center / Box 356460
Seattle, WA 98195-6460 USA
Phone: (206) 543-3891 / FAX: (206) 543-3915

November 20, 2002

Colorado Board of Licensure
To Whom It May Concern

Regarding: Marcy Bowers, MD

This letter will verify that Marcy Bowers, MD, successfully completed an approved four-year residency program in Obstetrics and Gynecology at the University of Washington School of Medicine from 1986-1990.

If you need additional information about Dr Bowers, please do not hesitate to contact me.

Sincerely,

Louis A Vontver, MD, MEd
Professor and Director of Education
Department of Obstetrics and Gynecology
University of Washington School of Medicine

LV/ejj

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 SE Quince St • P.O. Box 47866 • Olympia, Washington 98504-7866

December 4, 2002

Colorado Board of Medical Examiners
Attn Jan Seewald
1560 Broadway Suite 1500
Denver CO 80202

To Whom It May Concern:

I, Betty Elliott, Program Representative, do hereby certify that a standard search of the available records of the Medical Quality Assurance Commission indicates the following:

PHYSICIANS NAME	**Marci Bowers, MD**
LICENSE NUMBER:	**MD00027147**
ISSUE DATE:	**03-05-1990**
EXPIRATION DATE	**01-18-2004**
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If you have any questions or need additional information, please contact me by telephone at (360) 236-4785, by email at betty.elliott@doh.wa.gov, or in writing at Department of Health, Medical Quality Assurance Commission, PO Box 47866, Olympia, Washington 98504-7866.

Sincerely,

(SEAL)

B Elliott

Betty Elliott
Licensing Representative

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
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http://www.dora.state.co.us/medical

Department of Regulatory Agencies
Division of Registrations

DISCIPLINARY ACTION REPORT

PLEASE COMPLETE ALL BLANKS ON THIS FORM AND MAIL TO:

FEDERATION OF STATE MEDICAL BOARDS
400 Fuller Wiser Road
Suite 300
Euless, TX 76039-3855

Phone: 817-868-4000
Fax: 817-868-4099

****NO FEE REQUIRED*****

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

OCT 29 2002

DALE L. AUSTIN
DEPUTY EXECUTIVE VICE PRESIDENT
AND CHIEF OPERATING OFFICER

The Federation of State Medical Boards maintains a national databank of all disciplinary action taken by state licensing boards and/or other credentialing agencies. To complete your application we must have a report from the Federation. Please note: an unfavorable report does not automatically disqualify you from licensure in Colorado.

NAME Marci L. Bowers, MD

ADDRESS 1001 Broadway Suite # 207

CITY, STATE AND ZIP CODE Seattle WA 98122

DATE OF BIRTH

SOCIAL SECURITY NUMBER

MEDICAL SCHOOL U of Minnesota

DATE OF GRADUATION 6/86

I hereby authorize and request that the Federation of State Medical Boards of the United States Inc. provide a disciplinary history to the State of Colorado Board of Medical Examiners

Marci L. Bowers MD
Signature

Oct. 19, 2002
Date

L7

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5146
(303) 894-7715/894-7716
FAX (303) 894-7692
V/TDD (303)894-7880
http://www.dora.state.co.us/medical

Department of Regulatory Agencies
Division of Registrations

CHANGE OF ADDRESS FORM

The Medical Board requires that an address change be submitted in writing from the licensee. Please read and complete this form and return it to the Medical Board at 1560 Broadway, Ste 1300, Denver, CO 80202-5140 so that there is no misunderstanding about where we should send Medical Board correspondence.

Pursuant to Colorado law the preferred mailing address of any licensee or applicant is available to the public. This address is also available on the Medical Board Internet website. Thus, please carefully consider the address provided to the Board. The preferred address will also be used to mail all licenses, renewal notices and other official correspondence from the Medical Board. Your preferred mailing address may be a Post Office Box address.

If you do not indicate which address will be your preferred mailing address, the business address will constitute the preferred mailing address.

Per the Colorado State Board of Medical Examiner Rule Regarding the Maintenance of Current Address, we cannot accept a change of address that requests the address be changed for some, but not all communications. Additionally, we cannot accept a change of address which requires the Board to mark correspondence as "confidential."

Please note that there is a $5 fee to print a new computer generated license.

****

Business Address ___ **This is my preferred mailing address.**

1001 Broadway Suite #207
Seattle, WA 98122

Phone # (206) 328-3200 **Effective Date** 1/01/02

****

Home Address X **This is my preferred mailing address.**

8649 Fauntleroy Way SW
Seattle, WA 98136

Phone # (206) 940-4484 **Effective Date** 1/01/02

Print Name Marci L. Bowers **License #** _____

Signature Marci L. Bowers **Date Signed** 10/19/02

The Secretary of State of the United States of America
hereby requests all whom it may concern to permit the citizen/national
of the United States named herein to pass without delay or hindrance
and in case of need to give all lawful aid and protection.

Le Secrétaire d'Etat des Etats-Unis d'Amérique
Prie par les présentes toutes autorités compétentes de laisser passer le citoyen/
ressortissant des Etats-Unis titulaire du présent passeport, sans délai ni
difficulté et, en cas de besoin, de lui accorder toute aide et protection légitimes.

El Secretario de Estado de los Estados Unidos de América por el presente solicita a las
autoridades competentes permitir el paso del ciudadano o nacional de los Estados Unidos
aquí nombrado, sin demora ni dificultades, y en caso de necesidad, prestarle toda la
ayuda y protección lícitas.

Marci Bowers

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE/FIRMA DEL TITULAR

NOT VALID UNTIL SIGNED

PASSPORT

USA

Type / Type / Tipo: P
Code / Code / Código: USA
Passport No. / No. du Passeport / No. del Pasaporte: 075794471

Surname / Nom / Apellidos
BOWERS

Given names / Prénoms / Nombres
MARCI LEE

Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento
Sex / Sexe / Sexo: **F**
Place of birth / Lieu de naissance / Lugar de nacimiento
ILLINOIS, U.S.A.

Date of issue / Date de délivrance / Fecha de expedición
21 Sep 2000
Authority / Autorité / Autoridad
Seattle

Date of expiration / Date d'expiration / Fecha de caducidad
20 Sep 2010

Amendments / Modifications / Enmiendas
See Page 24

P<USABOWERS<<MARCI<LEE<<<<<<<<<<<<<<<<<<<<<<<<
075794471 6USA8011187F1009206<<<<<<<<<<<<<<02

Kevin Spitz 1-800-211-1476

Rule 220

COLORADO STATE BOARD OF MEDICAL EXAMINERS
RULES AND REGULATIONS CONCERNING FINANCIAL RESPONSIBILITY STANDARDS
INTRODUCTION

Basis: The general authority for the promulgation of rules and regulations by the State Board of Medical Examiners is set forth in Section 12-36-104(1)(a), C.R.S., as amended. Specific authority for the promulgation of rules regarding financial liability requirements is set forth in Section 13-64-301(1)(a), C.R.S., (1990).

Purpose: Part 3 of Article 64, Title 13, sets forth financial responsibility requirements to be met by all Colorado licensed physicians. However, the Board of Medical Examiners may, by rule, exempt or establish lesser standards for certain classes of license holders. These rules have been adopted by the Board of Medical Examiners in order to exempt from the requirements certain categories of licensees for whom the financial responsibility standards do not serve to enhance the public interest.

RULES AND REGULATIONS

1. Pursuant to the requirements of Section 13-64-301(1)(a), C.R.S., every physician who holds or desires to obtain a Colorado medical license must maintain commercial professional liability insurance coverage with an insurance company authorized to do business in this state in a minimum indemnity amount of five hundred thousand dollars per incident and one million five hundred thousand dollars annual aggregate per year [or meet alternative responsibility standards which comply with the provisions of Section 13-64-301(1)(c), (d), or (e)], except that this requirement is not applicable to a health care professional who is a public employee under the "Colorado Governmental Immunity Act".

2. Pursuant to these rules, a physician whose medical practice falls entirely within one or more of the following categories is exempt from the requirements set forth in paragraph 1, above:

   a. A federal civilian or military physician whose practice is limited solely to that required by his federal/military agency.

   b. A physician who is not engaged in the practice of medicine.

   c. A physician who is covered by individual commercial professional liability coverage (or an alternative which complies with Section 13-64-301(1)(c), (d) or (e)) maintained by an employer/contracting agency in the amounts set forth in paragraph 1, above

   (d.) A physician who provides uncompensated health care to patients, or who does not otherwise engage in any compensated patient care in Colorado.

3. Any physician who claims exemption from the financial responsibility requirements must provide such information as may be requested by the Board in order to establish eligibility for any such exemption.

Effective: 8/30/90; Revised: 3/3/90; Revised: 8/30/90; Revised: 09/30/99

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

For authorized use by:
SELF-QUERIER

MEDICAL MALPRACTICE PAYMENT REPORT

Report Number 5500000023215401

This report is maintained in: [X] **The National Practitioner Data Bank**
[ ] **The Healthcare Integrity and Protection Data Bank**

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. For additional information or clarification, contact the reporting entity identified in Section A.

A. REPORTING ENTITY

Entity Name: PHYSICIANS INSURANCE, A MUTUAL COMPANY
Address: 1730 MINOR AVE SUITE 1800
City, State, ZIP: SEATTLE, WA 98101-1499
Name or Office: SUSAN R. SIMPSON
Title or Department: CLAIMS REPRESENTATIVE
Telephone: (206)343-7300
Type of Report: CORRECTION OR ADDITION

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: BOWERS, MARCI L
Other Name(s) Used:
Gender: FEMALE
Organization Name:
Address: 1145 BROADWAY
City, State, ZIP: SEATTLE, WA 98122
Country:
Home Address:
City, State, ZIP:
Country:
Social Security Numbers (SSN):
Date of Birth:
Deceased: NO
Professional School(s) & Year(s) of Graduation: UNIV. OF MINNESOTA 1986
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Number, State of Licensure: 00027147, WA
Drug Enforcement Administration (DEA) Numbers:
Hospital Affiliation(s):

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

DISCLOSURE HISTORY

Report Number 5500000023215401

F. DISCLOSURE HISTORY

The report has been disclosed to the following entity(entities) for limited/restricted use under the statutory provisions specified in the report.

Date Released	Entity Name
12/04/2001	PACIFICARE OF OREGON 5 CENTERPOINTE DRIVE, SUITE 600 LAKE OSWEGO, OR 97035-8650 (503) 603-7280
Date Released	**Entity Name**
12/04/2001	WASHINGTON STATE HEALTH CARE AUTHORITY 1511 3RD AVE., STE. 201 SEATTLE, WA 98101- (206) 521-2010
Date Released	**Entity Name**
12/20/2001	UNITED HEALTHCARE OF CALIFORNIA 180 E. OCEAN BOULEVARD SUITE 500 LONG BEACH, CA 90802- (562) 951-6835
Date Released	**Entity Name**
01/04/2002	FIRST CHOICE HEALTH NETWORK, INC 601 UNION STREET, SUITE 1100 SEATTLE, WA 98101- (206) 268-2359
Date Released	**Entity Name**
01/16/2002	PREMERA BLUE CROSS 7001 220TH STREET, SW, MS463 MOUNTLAKE TERRACE, WA 98043-2124 (425) 670-4728

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

DISCLOSURE HISTORY

Report Number 5500000023215401

Date Released	Entity Name
01/29/2002	SWEDISH HEALTH SERVICES 747 BROADWAY MEDICAL STAFF SERVICES SEATTLE, WA 98122-4307 (206) 386-2550
02/08/2002	AETNA WEST REGION 1000 MIDDLE STREET, MC38 MIDDLETOWN, CT 06457- (860) 636-4217
04/15/2002	HEALTH VALUE MANAGEMENT INC DBA CHOICE C CHOICE CARE CONTRACT ADMINISTRATION 1100 EMPLOYERS BOULEVARD GREEN BAY, WI 54344- (920) 430-0640
09/17/2002	PRIVATE HEALTH CARE SYSTEMS 1100 WINTER ST WALTHAM, MA 02451- (800) 253-4417
10/04/2002	HEALTH VALUE MANAGEMENT INC DBA CHOICE C CHOICE CARE CONTRACT ADMINISTRATION 1100 EMPLOYERS BOULEVARD GREEN BAY, WI 54344- (920) 430-0640

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Chantilly, VA 20153-0832

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DISCLOSURE HISTORY

Report Number 5500000023215401

Date Released	Entity Name
11/08/2002	PRACTITIONER SELF-QUERY PO BOX 10832 CHANTILY, VA 20153- (180) 076-7673

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Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

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For authorized use by:
SELF-QUERIER

MEDICAL MALPRACTICE PAYMENT REPORT

Report Number 5500000023215421

This report is maintained in: [X] **The National Practitioner Data Bank**

[ ] **The Healthcare Integrity and Protection Data Bank**

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the *provisions of Title IV of Public Law 99-660, as amended, and 45 CFR Part 60. All information is confidential and may be* used only for the purpose for which it was disclosed. For additional information or clarification, contact the reporting entity identified in Section A.

A. REPORTING ENTITY

Entity Name: PHYSICIANS INSURANCE, A MUTUAL COMPANY
Address: 1730 MINOR AVE SUITE 1800
City, State, ZIP: SEATTLE, WA 98101-1499
Name or Office: PATRICIA C. BERGER
Title or Department: ASSOCIATE VICE PRESIDENT - LITIGATION MA
Telephone: (206)343-7300
Type of Report: CORRECTION OR ADDITION

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: BOWERS, MARCI L.
Other Name(s) Used:
Gender: FEMALE
Organization Name:
Address: 1145 BROADWAY
City, State, ZIP: SEATTLE, WA 98122
Country:
Home Address:
City, State, ZIP:
Country:
Social Security Numbers (SSN):
Date of Birth:
Deceased: NO
Professional School(s) & Year(s) of Graduation: UNIV. OF MINNESOTA 1986
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Number, State of Licensure: 00027147, WA
Drug Enforcement Administration (DEA) Numbers:
Hospital Affiliation(s):

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National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

DISCLOSURE HISTORY

Report Number 5500000023215421

F. DISCLOSURE HISTORY

The report has been disclosed to the following entity(entities) for limited/restricted use under the statutory provisions specified in the report.

Date Released	Entity Name
12/04/2001	PACIFICARE OF OREGON 5 CENTERPOINTE DRIVE, SUITE 600 LAKE OSWEGO, OR 97035-8650 (503) 603-7280
Date Released	**Entity Name**
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Date Released	**Entity Name**
01/04/2002	FIRST CHOICE HEALTH NETWORK, INC 601 UNION STREET, SUITE 1100 SEATTLE, WA 98101- (206) 268-2359
Date Released	**Entity Name**
01/16/2002	PREMERA BLUE CROSS 7001 220TH STREET, SW, MS463 MOUNTLAKE TERRACE, WA 98043-2124 (425) 670-4728

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DISCLOSURE HISTORY

Report Number 5500000023215421

Date Released	Entity Name
01/29/2002	SWEDISH HEALTH SERVICES 747 BROADWAY MEDICAL STAFF SERVICES SEATTLE, WA 98122-4307 (206) 386-2550
Date Released	**Entity Name**
02/08/2002	AETNA WEST REGION 1000 MIDDLE STREET, MC38 MIDDLETOWN, CT 06457- (860) 636-4217
Date Released	**Entity Name**
04/15/2002	HEALTH VALUE MANAGEMENT INC DBA CHOICE C CHOICE CARE CONTRACT ADMINISTRATION 1100 EMPLOYERS BOULEVARD GREEN BAY, WI 54344- (920) 430-0640
Date Released	**Entity Name**
09/17/2002	PRIVATE HEALTH CARE SYSTEMS 1100 WINTER ST WALTHAM, MA 02451- (800) 253-4417
Date Released	**Entity Name**
10/04/2002	HEALTH VALUE MANAGEMENT INC DBA CHOICE C CHOICE CARE CONTRACT ADMINISTRATION 1100 EMPLOYERS BOULEVARD GREEN BAY, WI 54344- (920) 430-0640

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DISCLOSURE HISTORY

Report Number 5500000023215421

Date Released	Entity Name
11/08/2002	PRACTITIONER SELF-QUERY PO BOX 10832 CHANTILY, VA 20153- (180) 076-7673

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Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

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DISCLOSURE HISTORY

Report Number 5500000023215471

F. DISCLOSURE HISTORY

The report has been disclosed to the following entity(entities) for limited/restricted use under the statutory provisions specified in the report.

Date Released	Entity Name
12/04/2001	PACIFICARE OF OREGON 5 CENTERPOINTE DRIVE, SUITE 600 LAKE OSWEGO, OR 97035-8650 (503) 603-7280
12/04/2001	WASHINGTON STATE HEALTH CARE AUTHORITY 1511 3RD AVE., STE. 201 SEATTLE, WA 98101- (206) 521-2010
12/20/2001	UNITED HEALTHCARE OF CALIFORNIA 180 E. OCEAN BOULEVARD SUITE 500 LONG BEACH, CA 90802- (562) 951-6835
01/04/2002	FIRST CHOICE HEALTH NETWORK, INC 601 UNION STREET, SUITE 1100 SEATTLE, WA 98101- (206) 268-2359
01/16/2002	PREMERA BLUE CROSS 7001 220TH STREET, SW, MS463 MOUNTLAKE TERRACE, WA 98043-2124 (425) 670-4728

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Chantilly, VA 20153-0832

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DISCLOSURE HISTORY

Report Number 5500000023215471

Date Released	Entity Name
01/29/2002	SWEDISH HEALTH SERVICES 747 BROADWAY MEDICAL STAFF SERVICES SEATTLE, WA 98122-4307 (206) 386-2550
02/08/2002	AETNA WEST REGION 1000 MIDDLE STREET, MC38 MIDDLETOWN, CT 06457- (860) 636-4217
04/15/2002	HEALTH VALUE MANAGEMENT INC DBA CHOICE C CHOICE CARE CONTRACT ADMINISTRATION 1100 EMPLOYERS BOULEVARD GREEN BAY, WI 54344- (920) 430-0640
09/17/2002	PRIVATE HEALTH CARE SYSTEMS 1100 WINTER ST WALTHAM, MA 02451- (800) 253-4417
10/04/2002	HEALTH VALUE MANAGEMENT INC DBA CHOICE C CHOICE CARE CONTRACT ADMINISTRATION 1100 EMPLOYERS BOULEVARD GREEN BAY, WI 54344- (920) 430-0640

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Chantilly, VA 20153-0832

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DISCLOSURE HISTORY

Report Number 5500000023215471

Date Released	Entity Name
11/08/2002	PRACTITIONER SELF-QUERY PO BOX 10832 CHANTILY, VA 20153- (180) 076-7673

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

DCN: 5500000027515082
Process Date: 10/20/2002

Unique Physician Identification Numbers (UPIN): E72307

D. SEARCH RESULT

Based on the subject identification information provided by you in Section C above, a search of the HIPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section C is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Section 1128E of the Social Security Act. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the HIPDB is confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

BEFORE THE COLORADO MEDICAL BOARD
STATE OF COLORADO

CASE NUMBER: 2016-6539

CEASE AND DESIST ORDER

IN THE MATTER OF THE UNAUTHORIZED AND UNLAWFUL PRACTICE OF MEDICINE BY **Marci Bowers, M.D.**

Respondent.

To: **Marci Bowers, M.D**
134 West Main Street, Suite 11
Trinidad, CO 81082

and

Marci Bowers, M.D
345 Lorton Ave, #101
Burlingame CA, 94010

The Licensing Panel ("Panel") of the Colorado Medical Board ("Board") considered information relating to a complaint alleging that Respondent engaged in the unauthorized and unlicensed practice of medicine in the state of Colorado.

The Panel HEREBY FINDS:

1. The Panel has jurisdiction over Respondent and the subject matter herein, and there exists credible evidence that Respondent has acted without the required license to practice medicine, in violation of Sections 12-36-106 (l)(a), (b), and 12-36-106 (2), Colorado Revised Statutes ("C.R.S.").

2. Respondent was licensed to practice medicine in Colorado on December 19, 2002, and was issued license number DR41164, which Respondent held continuously through August 4, 2011 when the license expired.

3. Respondent has not been licensed to practice medicine in Colorado as required pursuant to section 12-36-101, C.R.S*., et seq*., since August 4, 2011.

4. Respondent is not exempt from the licensing requirements of Article

36, Title 12, C.R.S.

5. From approximately September 4, 2014 through at least May 28, 2015, Respondent engaged in the unauthorized or unlicensed practice of medicine when Respondent maintained an office in Colorado for the purpose of treating patient LC. Specifically, Respondent prescribed antibiotics for patient LC who contacted Respondent's office in Trinidad, Colorado, and instructed her office staff located in Trinidad, Colorado to telephone the prescriptions to a pharmacy.

6. In maintaining an office for the purpose of examining or treating persons afflicted with disease, injury or defect of body or mind, Respondent is practicing medicine as defined in Section 12-36-106(1), C.R.S., without the required license.

7. Respondent's conduct constitutes the unlicensed practice of medicine, in violation of Sections 12-36-106(2) and/or 12-36-129(1), C.R.S.

WHEREFORE, The Colorado Medical Board, having reviewed all available information in this matter, **ORDERS** Marci Bowers **TO IMMEDIATELY CEASE AND DESIST THE UNLICENSED PRACTICE OF MEDICINE** in the state of Colorado.

SPECIFICALLY, the Board **HEREBY ORDERS** that Respondent immediately **CEASE AND DESIST** the maintenance of an office or other place for purpose of examining or treating persons afflicted with disease, injury or defect of body or mind in the state of Colorado in violation of Sections 12-36-106 (l)(c), 12-36-106(2), and/or 12-36-129(1), C.R.S.

The Licensing Panel authorized the undersigned representative to sign this **CEASE AND DESIST ORDER** on its behalf.

DATED this 16th day of January, 2017.

THE COLORADO MEDICAL BOARD

BY: 

Karen M. McGovern
Interim Program Director
Colorado Medical Board

NOTICE OF RIGHT TO REQUEST HEARING: Within ten days after service of this Cease and Desist Order, Respondent may request a hearing on whether such acts or practices in violation of Article 36 of Title 12, C.R.S. have occurred. Such hearing shall