The Colorado State Board of Examiners in the Basic Sciences 1838

CERTIFICATE NUMBER 10883 DATE MAR 7 1974

BY RECIPROCITY, STATE _____ BY EXAMINATION _____

BY WAIVER - NATIONAL MEDICAL X OSTEOPATHIC _____ PODIATRY _____

BY VALID LICENSE, STATE _____ BRANCH MEDICAL

NAME DONALD WARREN APETKAR REG. NO. 11875

ADDRESS 938 Eudora Street, Denver, Colorado 80220

DATE OF BIRT [redacted] HEIGHT 5'10½ WEIGHT 165

COLOR OF HAIR BROWN COLOR OF EYES BROWN

Norman Zwick
PRESIDENT

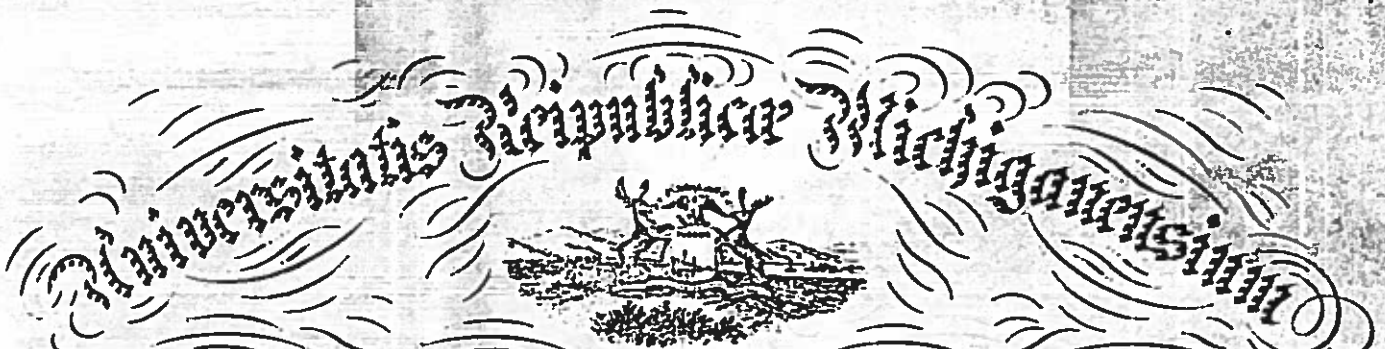
Esther B Starke
SECRETARY

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

CIRCULATION AND RECORDS DEPARTMENT
PHYSICIAN'S HISTORICAL RECORD

DATE: 06-28-74
TIME: 11:09 AM

NAME: APTEKAR, DONALD WARREN, M.D.
ADDRESS: GENERAL ROSE MEM HOSP
DENVER CO 80220
MEDICAL EDUCATION NUMBER: 025 01 230 04
BIRTHPLACE: DETROIT, MI
BIRTHDATE: [redacted]
MEDICAL EDUCATION (SCHOOL YEAR):
UNIVERSITY OF MICHIGAN MEDICAL SCHOOL, ANN ARBOR 1973
NATIONAL BOARD CERTIFICATION:
LICENSES:
PHYSICIAN'S PROFESSIONAL ACTIVITIES:
NOT CLASSIFIED
PRIMARY SPECIALTY: UNSPECIFIED
SECONDARY SPECIALTY: UNSPECIFIED
TERTIARY SPECIALTY: UNSPECIFIED
SPECIALTY BOARD CERTIFICATION:
MEMBER OF AMA:
NATIONAL SCIENTIFIC MEDICAL SOCIETIES:
PROFESSORIAL APPOINTMENT:
CURRENT MEDICAL TRAINING: INTERN
HOSPITAL: GENERAL ROSE MEM HOSP DENVER 80220
DATES OF TRAINING: 06/73-06/74
SPECIALTY: UNSPECIFIED
SPECIALTY: UNSPECIFIED
INTERNSHIP:
RESIDENCY:
DEPARTMENT OF INVESTIGATION: no-no



Universitatis Virginiae Michiganensis

PROCURATORES OMNIBUS HAS LITERAS PERLECTURIS

Salutem

Scitis **Donald Warren Aptekar** ingenuis moribus notis a Collegio Medicinae et Chirurgiae Professoribus commendatum ut qui in studio et disciplina scientiaque Medicinae et Chirurgiae Artium bene probatus sit gradu

Doctoris in Arte Medica

nos ornavisse cujus in rei testimonium has literas Praesidis et Secretarii et Professorum nomine manuque gerentes sigilloque Universitatis signatas in manus ejusdem dedimus.

Datum ex aedibus Universitatis die secundo Junii anno salutis millesimo nongentesimo septuagesimo tertio Annoque Universitatis Republicae Michiganensium centesimo quinquagesimo septimo

R. L. Kennedy Secretarius

Professores

R. H. Fleming Praeses

General Rose Memorial Hospital

University of Colorado, School of Medicine

Denver, Colorado

This is to certify that

Donald W. Aptekar, M.D.

has completed with satisfaction and credit

Internship

from June 22, 1973 to June 21, 1974

Certificate No. 235

June 14, 1974

Evelyn E. Robinson

Ernest W. Keel, M.D.

Harold J. Horner, M.D.

PLEASE PRINT OR TYPE

LAST NAME	FIRST NAME	M	LICENSE #	SOCIAL SECURITY #
APTEKAR	DONALD		18738	

BOTH SIDES OF THIS FORM MUST BE TOTALLY AND ACCURATELY COMPLETED OR IT WILL BE RETURNED TO YOU AND WILL DELAY YOUR RENEWAL.

Read both sides carefully before you begin. Make a copy for your records.

COLORADO BOARD OF MEDICAL EXAMINERS 1997 LICENSE RENEWAL QUESTIONNAIRE

The Colorado Medical Practice Act mandates that a questionnaire be mailed to, and completed by, each physician wishing to renew his/her license at the time of expiration. **COMPLETION OF THIS QUESTIONNAIRE IS NOT OPTIONAL**. Each question must be answered. Answering "yes" to any of these questions **will not** automatically delay renewal of your license.

	YES	NO
A) Since you last renewed your Colorado medical license, have you:		
1. had any adverse action taken against you by any licensing agency in another state or country, any peer review body, any health care institution, any professional or medical society or association, any governmental agency, any law enforcement agency, or any court?	☐	☒
2. surrendered a license or other authorization to practice medicine in another state or jurisdiction or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?	☐	☒
3. had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? (Note: Please include any payments you have personally made.)	☐	☒
4. been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier?	☐	☒
B) Since you last renewed your Colorado medical license, have either of the following been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "yes" to the items below if any of these same actions are currently pending. (Note: You must answer yes if you have withdrawn or failed to proceed with an application for any of these items.)		
5. Medical staff membership or clinical privileges at any hospital or health care institution?	☐	☒
6. DEA registration?	☐	☒
C) Since you last renewed your Colorado license, have you:		
7. had any felony or misdemeanor charges, or any traffic citations involving drugs or alcohol, brought against you?		
8. illegally or excessively used any controlled substance, habit forming drug, prescription medication, or alcohol? You need not report behavior which is already known to the Colorado Board of Medical Examiners or the Colorado Physician Health Program		
9. engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine safely and competently? You need not report behavior or conditions which are already known to the Colorado Board of Medical Examiners or the Colorado Physician Health Program		

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, PLEASE PROVIDE THE FOLLOWING INFORMATION. IF YOU NEED TO ATTACH ANOTHER SHEET OF PAPER OR DOCUMENTS, PLEASE PUT YOUR NAME AND LICENSE NUMBER ON EACH ATTACHMENT.

Questions 1 and 2: Indicate name and address of the entity taking the action or investigating conduct/allegations, the date of the action and specify conduct/allegations upon which the action or investigation was initiated. Please include documentation of any charges and/or final action.

Questions 3 and 4: Indicate name and address of insurance carrier, reasons for action, and date of alleged conduct. Attach copy of notification from carrier.

Questions 5 and 6: Indicate name and address of facility or organization, date of action, and specific conduct/allegations upon which action was taken. Attach a copy of notification from agency or organization taking action.

Question 7: Indicate name and address of court of jurisdiction, violation charged, date of alleged violation, and disposition of each violation charged.

Questions 8 and 9: Provide description of condition, date of onset, dates and summary of any treatment, name and address of all treatment providers, and current status of condition.

– OVER –

1997 RENEWAL INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility.

☐ **I WISH TO CHANGE FROM INACTIVE TO ACTIVE STATUS: FEE - $195.** You must complete a different form. Please call the Board Office at (303) 894-7719 to request a Reactivation Form.

☒ **ACTIVE LICENSE: FEE - $195.** I wish to renew my license via ACTIVE STATUS. I meet (or claim exemption from) the financial responsibility standards as indicated below: **You must check at least one.**

☐ 1. I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year.

Company: COPIC ☒ **Doctors Company** ☐ **St. Paul** ☐ **Other (Specify**_____)

NOTE: Please supply your insurance policy number: * CRF960449

☒ 2. I am covered by individual commercial professional liability insurance maintained by an employer/contracting agency in accordance with the requirements noted in "1" above.

☐ 3. I am a federal civilian or military physician whose practice is limited solely to that required by my federal or military agency.

☐ 4. I am a public employee whose practice is limited solely to that covered by the Colorado Governmental Immunity Act.

☐ 5. I do not engage in any patient care whatsoever within the state of Colorado, including prescribing. I am, however, engaged in active medical practice in another state or foreign jurisdiction. (NOTE: You may wish to consider renewing your license via inactive status - see below).

☐ 6. My medical practice does not involve any patient care whatsoever (e.g., administrator, researcher, academician, non-medical endeavor. (NOTE: You may wish to consider renewing your license via inactive status - see below.)

☐ 7. I provide limited or occasional, uncompensated care to patients and I do not otherwise provide any compensated patient care whatsoever.

☐ 8. I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance:

☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

NOTE: The Commissioner of Insurance approves alternatives for financial responsibility. Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used. The address of the Commission Office is: 1560 Broadway, Suite 850, Denver, Colorado 80202: (303) 894-7499.

☐ **INACTIVE LICENSE: FEE: $100.** I wish to renew my license via INACTIVE STATUS. (NOTE: this category is primarily intended for retired physicians and those practicing outside Colorado.) Malpractice insurance is not required for inactive license holders. **I understand that I may not practice medicine, including prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license. I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional $95.00. I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.**

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 Colorado Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

Signature of Physician	Date	Phone #	Fax ##
Donald W Gotter	4-4-97	3993315	355-7088

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee, and 3) the Physician Survey (optional) in the enclosed return envelope. Direct questions to: **(303) 894-7690 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver, CO 80202-5140**

COLORADO BOARD OF MEDICAL EXAMINERS 1999 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	M	SOCIAL SECURITY #	COLORADO 5 DIGIT LICENSE #
APTEKAR	DONALD	W		18738

Instructions Print or type name and Social Security Number and license number above Fill in the circle that corresponds to each number of your license number

BOTH SIDES OF THIS FORM MUST BE TOTALLY AND ACCURATELY COMPLETED OR IT WILL BE RETURNED TO YOU AND WILL DELAY YOUR RENEWAL.
Read both sides carefully before you begin. Make a copy for your records.

The Colorado Medical Practice Act mandates that a questionnaire be mailed to, and completed by, each physician wishing to renew his/her license at the time of expiration **COMPLETION OF THIS QUESTIONNAIRE IS NOT OPTIONAL** Each question must be answered. Answering "yes" to any of these questions **will not** automatically delay renewal of your license

	YES	NO
A) Since you last renewed your Colorado medical license, have you		
1. had any adverse action taken against you by any licensing agency in another state or country, any peer review body, any health care institution, any professional or medical society or association, any governmental agency, any law enforcement agency, or any court?	☐	☒
2 surrendered a license or other authorization to practice medicine in another state or jurisdiction or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?	☐	☒
3 had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? (Note Please include any payments you have personally made)	☐	☒
4 been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier?	☐	☒
B) Since you last renewed your Colorado medical license, have either of the following been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "yes" to the items below if any of these same actions are currently pending (Note You must answer yes if you have withdrawn or failed to proceed with an application for any of these items)		
5 Medical staff membership or clinical privileges at any hospital or health care institution?	☒	☒
6 DEA registration?	☐	☒
C) Since you last renewed your Colorado license, have you		
7 had any felony or misdemeanor charges, or any traffic citations involving drugs or alcohol, brought against you?		
8 illegally or excessively used any controlled substance, habit forming drug, prescription medication, or alcohol? You may answer NO if the behavior is already known to the Colorado Physician Health Program		
9 engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine safely and competently? You may answer NO if the behavior or conditions are already known to the Colorado Physician Health Program		

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, PLEASE PROVIDE THE FOLLOWING INFORMATION. IF YOU NEED TO ATTACH ANOTHER SHEET OF PAPER OR DOCUMENTS, PLEASE PUT YOUR NAME AND LICENSE NUMBER ON EACH ATTACHMENT.

Questions 1 and 2 Indicate name and address of the entity taking the action or investigating conduct/allegations, the date of the action and specify conduct/allegations upon which the action or investigation was initiated Please include documentation of any charges and/or final action

Questions 3 and 4 Indicate name and address of insurance carrier, reasons for action, and date of alleged conduct Send copy of final action, amount of settlement, copy of report from National Practitioner Data Bank and a clinical narrative of the case, including patient's name

Questions 4 Attach copy of notification from insurance carrier

Questions 5 and 6 Indicate name and address of facility or organization, date of action, and specific conduct/allegations upon which action was taken Attach a copy of notification from agency or organization taking action

Question 7 Indicate name and address of court of jurisdiction, violation charged, date of alleged violation, and a copy of the final disposition of each violation charged.

Questions 8 and 9 Provide description of condition, date of onset, dates and summary of any treatment, name and address of all treatment providers, and current status of condition.

– OVER –

98145025

1999 RENEWAL INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility

☐ **I WISH TO CHANGE FROM INACTIVE TO ACTIVE STATUS: FEE - $305.** You must complete a different form Please call the Board Office at (303) 894-7719 to request a Reactivation Form

☒ **ACTIVE LICENSE: FEE - $305** *I wish to renew my license via ACTIVE STATUS. I meet (or claim exemption from) the* financial responsibility standards as indicated below· **You must check at least one.**

☒ 1 I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year

Company: COPIC ☒ **Doctors Company** ☐ **St. Paul** ☐ **Other (Specify_____)**

NOTE: Please supply your insurance policy number: _____

☐ 2 I am covered by individual commercial professional liability insurance maintained by an employer/contracting agency in accordance with the requirements noted in "1" above

☐ 3 I am a federal civilian or military physician whose practice is limited solely to that required by my federal or military agency

☐ 4 I am a public employee whose practice is limited solely to that covered by the Colorado Governmental Immunity Act

☐ 5 I do not engage in any patient care whatsoever within the state of Colorado, including prescribing I am, however, engaged in active medical practice in another state or foreign jurisdiction. (NOTE You may wish to consider renewing your license via inactive status - see below)

☐ 6 My medical practice does not involve any patient care whatsoever (e g , administrator, researcher, academician, non-medical endeavor (NOTE You may wish to consider renewing your license via inactive status - see below)

☐ 7 *I provide limited or occasional, uncompensated care to patients and I do not otherwise provide any compensated patient care* whatsoever

☐ 8 I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance (Must have approval from the Colorado Commissioner of Insurance See note below)

☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

NOTE The Commissioner of Insurance approves alternatives for financial responsibility. Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used The address of the Commission Office is 1560 Broadway, Suite 850, Denver, Colorado 80202 (303) 894-7499

MAKE CHECKS PAYABLE TO: COLORADO BOARD OF MEDICAL EXAMINERS

☐ **INACTIVE LICENSE FEE - $150** I wish to renew my license via INACTIVE STATUS. (NOTE. this category is primarily intended for retired physicians and those practicing outside Colorado) Malpractice insurance is not required for inactive license holders **I understand that I may not practice medicine, including prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional $155.00. I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.**

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 Colorado Medical Practice Act, [illegible] false information is grounds for denial, suspension or revocation of a medical license

Signature of Physician	Date	Phone #	Fax ##
Donald W Fletcher	4-12-99	303-399-3315	303-355-7088

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee, and 3) the Physician Survey (optional) in the enclosed return envelope Direct questions to· **(303) 894-7719 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver, CO 80202-5140**

COLORADO BOARD OF MEDICAL EXAMINERS
2001 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #	LICENSE #
APTEKAR	DONALD	W		18738

PLEASE PRINT LEGILBY. KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

NOTE: The Colorado Medical Practice Act mandates that all licensed physicians wishing to renew their Colorado medical licenses must complete this questionnaire and renewal application

INSTRUCTIONS: Print or type your name, social security number and license number in the boxes above Answer each question below, and provide the information and documentation requested for each "yes" response

RESPONDING "YES" TO ANY OF THESE QUESTIONS WILL NOT DELAY RENEWAL OF YOUR LICENSE.
AN INCOMPLETE OR INACCURATE FORM, HOWEVER, WILL RESULT IN DELAY OF YOUR RENEWAL. COMPLETE BOTH SIDES OF THIS FORM.

A) Since you last renewed your Colorado medical license, have you

1 had any adverse action taken against you by any licensing agency in another state or country, any peer review body, health care facility, professional or medical society or association, governmental agency, law enforcement agency, or court of law?
☐ YES ☒ NO

If "YES", provide a detailed summary of the events, which led to the adverse action Include the name and address of the entity that took the action, the date of the action, correspondence from the entity regarding the matter, and whether action is still pending

2 surrendered a license or other authorization to practice medicine in another state or jurisdiction, or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?
☐ YES ☒ NO

If "YES", provide a detailed summary of the events, which led to the adverse action Include the name and address of the entity that took the action, the date of the action, correspondence from the entity regarding the matter, and whether action is still pending

3 had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? NOTE Include any payments you have made personally ☐ YES ☒ NO

If "YES", provide a detailed clinical summary of your care and treatment of the patient Include the name of the patient, the amount and date of settlement, and a current copy of your complete National Practitioner Data Bank report (The Board may request patient records in the matter at a later date)

4 been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier? ☐ YES ☒ NO

If "YES", provide a copy of the notification from the insurance carrier and a summary of the events, which led to the denial If you do not have a copy of the notification, contact the insurance carrier to obtain one

5 had any felony or misdemeanor charges of any kind brought against you? Had any traffic citations involving drugs or alcohol, brought against you? Regardless of the case disposition, you **must** answer yes if you have been charged

If "YES", provide a detailed summary of the events, which led to the charges or citation Include with your summary a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction

6 illegally or excessively used any controlled substance, habit-forming drug, prescription medication or alcohol? You may answer "NO" if the behavior is already known to the Colorado Physician Health Program (CPHP)

If "YES", provide a detailed summary of the condition or event Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers

7 engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine with skill and safety to patients? You may answer "NO" if the behavior is already known to the Colorado Physician Health Program (CPHP)

If "YES", provide a detailed summary of the condition or event Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers

B) Since you last renewed your Colorado medical license, have either of the following been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "YES" to the items below if any of these actions are currently pending NOTE You must answer "YES" if you have withdrawn or failed to proceed with an application for any of these items

1 Medical staff membership or clinical privileges at any hospital or healthcare facility? ☐ YES ☒ NO

If "YES", provide a detailed summary of the conduct/allegations upon which action was taken Include the notification to you from the hospital(s) or facility(s) If you do not have the notification(s), contact the hospital(s) or facility(s) to obtain one

2 *DEA registration?* ☐ YES ☒ NO

If "YES", provide a detailed summary of the conduct/allegation upon which action was taken Include the notification from DEA If you do not have a copy of the notification, contact DEA to obtain a copy

HAVE YOU PREVIOUSLY REPORTED ANY OF THE ABOVE MATTERS TO THE BOARD? ☐ **YES** ☐ **NO**
IF YES, PROVIDE DOCUMENTATION IN SUPPORT OF YOUR RESPONSE. IF APPLICABLE, PROVIDE A COPY OF THE FINAL DISPOSITION FROM THE BOARD.

2001 LICENSE RENEWAL QUESTIONNAIRE AND INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility Please be advised, you CANNOT use this renewal form to change your status from FROM INACTIVE TO ACTIVE You must complete a reactivation application to reactivate your license Please call the Board Office at (303) 894-7690 to request a reactivation application This is a process separate and independent from the renewal process

☑ ACTIVE LICENSE FEE - $315 I wish to renew my license in ACTIVE STATUS I meet (or claim exemption from) the financial responsibility standards as indicated below You **must check at least one.**

☑ I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year

☒ COPIC ☐ Doctors Company ☐ St Paul ☐ Other (Specify)_____

NOTE Please supply your insurance policy number _____

- ☐ I am a federal civilian or military physician whose practice is limited solely to that required by my federal/military agency
- ☐ I am a physician who is not engaged in the practice of medicine
- ☐ I am 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 above
- ☐ I am a physician who provides uncompensated health care to patients, or who does not otherwise engage in any compensated patient care in Colorado
- ☐ I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance (Must have approval from the Colorado Commissioner of Insurance See note below)

☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

NOTE The Commissioner of Insurance approves alternatives for financial responsibility Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used The address of the Commission Office is 1560 Broadway, Suite 850, Denver, Colorado 80202 (303) 894-7499

☐ INACTIVE LICENSE FEE - $160 I wish to renew my license in INACTIVE STATUS Malpractice insurance is not required for inactive license holders **I understand that I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license.** I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations

MAKE CHECKS PAYABLE TO: COLORADO BOARD OF MEDICAL EXAMINERS

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 Colorado Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license

Donald W Aptekar 04·11·01

Signature of Physician **Date**

DONALD W. APTEKAR 18738

Print name of physician **(printed name and license number must be legible to process this form)** **License #**

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee and 3) the Physician Survey (optional) in the enclosed return envelope Direct questions to (303) 894-7690 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver CO 80202-5140

Renewal - DR.0018738

Name	Donald Warren Aptekar
Credential	DR.0018738

Fee Details

Renewal Fee	$2.00
Renewal Fee	$334.00
Renewal Fee	$3.00
Renewal Fee	$18.00
Renewal Fee	$144.00
	$501.00

DR Renewal Questionnaire

PART I: MANDATORY RENEWAL QUESTIONNAIRE

You must answer "YES" or "NO" to each question below. If you answer "YES" to a question, you must mail a copy of this questionnaire and a detailed explanation to include dates, amounts and contact information, to the Board for each "YES" answer within **thirty (30) days** of submitting your renewal. If the matter has already been disclosed to the Board, you must send a letter to the Board providing the case number and identifying information. If no documentation is received, a case may be opened and a complaint issued for an explanation of each "YES" answer.

Mail all documentation to:

Colorado Medical Board, ATTN: Renewal, 1560 Broadway, Suite 1350, Denver, CO 80202

SECTION A: SINCE YOU LAST RENEWED YOUR COLORADO MEDICAL LICENSE:

1. Have you been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any health care facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law, whether involuntary or in lieu of investigation?

No

2. Have you surrendered a license or other authorization to practice medicine in another state or jurisdiction, or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?

If you answer YES to question number 2, you must provide a detailed summary of the events which led to the charges or citation. Include a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.

No

3. Have you, in any state, been denied medical liability insurance, or has your medical liability insurance coverage been limited, restricted or terminated by action of the insurance carrier?

If you answer YES to question number 3, you must provide a copy of the notification from the insurance carrier and a summary of the events which led to the action by the carrier. If you do not have a copy of the notification, contact the insurance carrier to obtain one.

No

4. Have you had any felony or misdemeanor charges of any kind brought against you? Have you had any traffic citations involving drugs or alcohol brought against you? Regardless of the case disposition, you must answer YES if you have been charged.

If you answer YES to question number 4, you must provide a detailed summary of the events which led to the charges or citation. Include a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.

5. **For question 5, you must answer YES** if any of these actions are currently pending, or if you have withdrawn or failed to proceed with an application for these items.

Has your medical staff membership or clinical privileges at any hospital or healthcare facility been involuntarily or in lieu of investigation reduced, limited, placed on probation, not renewed or relinquished, or been denied, revoked or suspended?

If you answer YES to questions 5, you must provide a detailed summary to the Board of the conduct/allegation upon which action was taken.

No

6. **For question 6, you must answer YES** if any of these actions are currently pending, or if you have withdrawn or failed to proceed with an application for these items.

Has your DEA registration been involuntarily or in lieu of investigation reduced, limited, placed on probation, not renewed or relinquished, or been denied, revoked or suspended?

If you answer YES to questions 6, you must provide a detailed summary to the Board of the conduct/allegation upon which action was taken. And you must include the notification from the DEA. If you do not have a copy of the notification, contact the DEA to obtain a copy.

No

SECTION B IN THE LAST TWO YEARS:

7. Do you now abuse or excessively use, or have you in the last two years abused or excessively used, any habit forming drug, including alcohol, or any controlled substance that has a) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or b) affected your ability to practice as a physician safely and competently?

You may answer NO if the behavior or condition or use of such substances is already known to the Colorado Physician Health Program (CPHP) or you have entered into a Confidential Agreement with the Board. “Known to CPHP” means that you have informed CPHP of your behavior, condition or use of such substances and you are complying with all of CPHP’s requirements for evaluation, treatment and/or monitoring.

If you answer YES to question 7, you must provide a detailed summary of the behavior, condition or substance use. Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers.

8. In the last two years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a physician safely and competently, such as bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder?

You may answer NO if the behavior or condition or use of such substances is already known to the Colorado Physician Health Program (CPHP) or you have entered into a Confidential Agreement with the Board. “Known to CPHP” means that you have informed CPHP of your behavior, condition or use of such substances and you are complying with all of CPHP’s requirements for evaluation, treatment and/or monitoring.

If you answer YES to question 8, you must provide a detailed summary of the behavior, condition or substance use. Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers.

PART 2: MANDATORY ATTESTATION

9. **By submitting this application for renewal of my license, 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 Colorado Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.**

I wish to to renew my license in ACTIVE status, therfore I attest that I meet (or claim exemption from) the financial responsibility standards as indicated below. (select the correct option A-I) If you are currently in Active status an wish to change to Inactive status you cannot renew online and must contact the Division at 303-894-2984.

I am currently in INACTIVE status and am exempt from the provisions above. (If so, you must select option "J"). *If you wish to change to ACTIVE status, you must first renew your license in inactive status, and then submit the reactivation application and fee. The reactivation application is available on the Medical Board website.

Please select only 1 item below.

A. I maintain commercial professional liability insurance with COPIC, in minimum indemnity amounts of at least $1,000,000 per incident and $3,000,000 annual aggregate per year.

DR Renewal HPPP

Healthcare Professions Profiling Program ACTIVE status only:

REMINDER:

Healthcare Professions Profile Program (HPPP): All Active status licensees must maintain their Healthcare Professions Profile with current information. This profile must be updated within 30 days of any change or reportable event.

After you have completed and paid for you renewal please visit www.dora.colorado.gov/professions/hppp if you need to review and/or update your Profile. Please note: The Profile database is a separate system from our renewal system and uses a different login and password than the ones you used to renew your license.

If you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profile Program (HPPP) at: dora_dpo_hppp@state.co.us or (303) 894-5942.

After you have read the above, please click the "Next" button below.

Review

Please make sure to PRINT THIS SCREEN for your records. To do so, you can click the button in the upper right hand corner of this screen labeled "Print Review". You will not be able to print after you leave this review screen.

Renewal - DR.0018738

Name	Donald Warren Aptekar
Credential	DR.0018738

Fee Details

Renewal Fee	$2.00
Renewal Fee	$238.00
Renewal Fee	$18.00
Renewal Fee	$162.00
	$420.00

Affidavit of Eligibility - Screening Present

AFFIDAVIT OF ELIGIBILITY

1. Do you currently reside in and are you physically present in the United States?
   Yes

Affidavit of Eligibility - Screening Doc Change

AFFIDAVIT OF ELIGIBILITY

2. Are you a United States Citizen and the State or Federally issued document, in which you proved your legal status in the United States is still valid **and** has not expired since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

-OR-

Are you Not a United States Citizen, but are lawfully present in the United States **and** your legal status within the United States has not changed **and** the legal documents used to prove lawful presence have not changed since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

If you need to update your lawful presence information, select no and you will be prompted to complete a new Affidavit of Eligibility. Otherwise, if your information has not changed, select yes to move forward.
   Yes

Affidavit of Eligibility

AFFIDAVIT OF ELIGIBILITY

Pursuant to C.R.S. 24-34-107, ALL applicants for original licensure* or licensees renewing or reinstating a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

** The word "licensure" is used as a general term. While most of the professions and occupations are licensed, others may be certified, registered or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.*

3. Please enter your Full Legal Name

Affidavit of Eligibility - Section A

Section A: LAWFUL PRESENCE in the United States

4. Select one of the following Lawful Presence types below and click "Next" when done:

Affidavit of Eligibility - Section B.1

Section B: SECURE AND VERIFIABLE DOCUMENTS

5. Do you have a State or Federal government issued identification?

These include:

- Driver's License or Permit
- Government Issued ID Card
- Valid U.S. Military Common Access Card
- Colorado Department of Corrections Inmate ID
- Tribal ID Card
- U.S. Passport
- Certificate of Naturalization
- Certificate of (U.S.) Citizenship
- Valid Temporary Resident card
- Valid I-94 issued by Canadian government
- Valid I-94 with refugee/asylum stamp

Affidavit of Eligibility - Section B.1 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

6. Select one of the following Government Issued Identification:

7. Enter the name of State or Federal Agency that issued the identification:

8. Enter your full name as shown on the driver's license or State/Federal issued identification:

9. Enter the State/Federal government issued license/ID number:

10. Enter the expiration date of the license/ID:

11. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.2

Section B: SECURE AND VERIFIABLE DOCUMENTS

12. Do you have a Valid I-766 (Employment Identification Card)?

Affidavit of Eligibility - Section B.2 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

13. Enter the issuing Federal Agency:

14. Enter the name as listed on the card:

15. Enter the Alien number (A#):

16. Enter the card number:

17. Enter the Valid From Date:

18. Enter the Expiration Date:

19. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.3

Section B: SECURE AND VERIFIABLE DOCUMENTS

20. Do you have a Valid I-551 (Resident Alien or Permanent Resident Card)?

Affidavit of Eligibility - Section B.3 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

21. Enter the issuing Federal Agency:

22. Enter the name as listed on the card:

23. Enter the Alien Number (A#):

24. Enter the country of birth:

25. Enter the card expiration date:

26. Enter the Residence Since date:

27. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.4

28. Do you have a Valid Foreign Passport with an unexpired Visa with proper classification for work authorization, and an unexpired I-94?

Affidavit of Eligibility - Section B.4 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

29. Enter the issuing foreign country:

30. Enter the Passport Number:

31. Enter the Visa Number:

32. Enter the Visa Class (Examples: J-1, P-1 H-1B, etc.):

33. Enter the Date of Entry:

34. Enter the Until Date:

35. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.5

Section B: SECURE AND VERIFIABLE DOCUMENTS

36. Do you have a valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa?

Affidavit of Eligibility - Section B.5 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

37. Enter the issuing foreign country:

38. Enter the Passport Number:

39. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section C

Section C: Attestation

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.
- I understand that 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 in the second degree, as defined in section 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified on the previous pages and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the information on the previous pages must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

40. By entering your full legal name below you attest that you have read and understand the above information.

41. Please enter today's date below:

DR Renewal Attestation

The below attestations apply to your license's CURRENT status. You may not change your status through online renewal. To change your status, please contact the licensing office at dora_registrations@state.co.us or 303-894-7800.

By renewing my license in INACTIVE status, I attest that:

- I understand malpractice insurance is not required for Inactive license holders; however, I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an Active license. I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee. I also understand that if I have not actively practiced medicine for two (2) years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.

By renewing my license in ACTIVE status, I attest that:

- I have not abused or excessively used any habit forming drug, including alcohol, or any controlled substance that has: 1) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or, 2) affected my ability to practice as a physician safely and competently, at any time during the past two years, up to and including today's date.

  AND

  In the last two years, I have not been diagnosed with or treated for an illness or condition that significantly disturbs my cognition, behavior, or motor function, and that may impair my ability to practice as a physician safely and competently, such as bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder

  OR

  The illness or condition or the use of substances, as defined above, is: 1) already known to the Colorado Physician Health Program ("CPHP") and I have made, or will make known within 30 days, any requisite disclosure to the Board pursuant to section 12-36-118.5 and any attendant regulations; or, 2) I have entered into a Confidential Agreement with the Board. For the purpose of this attestation, "Known to CPHP" means that I have informed CPHP of my condition or use of such substances and I am complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

- In the last 2 years, no adverse action has been taken against my license by another licensing agency, a peer review body, a health care institution, a residency or postgraduate training program, a professional or medical society or association, a governmental agency, a law enforcement agency, or a court for acts or conduct which, would constitute grounds for disciplinary or adverse actions pursuant to the Medical Practice Act or its attendant rules. For the purpose of this attestation, an adverse action by a law enforcement agency includes: 1) all felony charges; 2) all misdemeanor charges; or, 3) traffic charges/citations involving alcohol, controlled substances, or any other habit-forming drug.

  OR

  I have reported, or will report within 30 days, any adverse action to the Board in accordance with the requirements of the Medical Practice Act.

- In the last 2 years, I have not been denied medical liability insurance and no liability insurance coverage has been limited, restricted, or terminated by action of the insurance carrier in this or any other state.

  OR

  I have reported, or will report within 30 days, any denial or limitation of medical liability coverage to the Board.

- I have established and will continuously maintain professional liability insurance as required by §13-64-301, C.R.S.

Click Next to proceed.

GLOBAL HPPP Renewal Attestation

Pursuant to section 24-34-110, C.R.S., all Active and Retired status licensees must maintain a current Healthcare Professions Profile. Reportable events and/or changes to information must be made within 30 days. For more information about this Program and to update your profile, visit www.dora.colorado.gov/professions/hppp.

By renewing your Active or Retired license, you attest to the following:

I have updated my Healthcare Professions Profile to current date and/or I will make any updates within 30 days of any reportable event or change, and subsequent updates will be made within 30 days. This requirement is in addition to any requirement by a profession's practice act. Examples of reportable events or changes that must be updated on a profile include, but are not limited to, location of practice, public actions issued by any jurisdiction, felonies and crimes of moral turpitude, malpractice settlements/judgments, etc. To update a Healthcare Professions Profile, or for more information on the Healthcare Professions Profile Program (HPPP) and its requirements, visit www.dora.colorado.gov/professions/hppp or call 303-894-5942.

If your status is Inactive you are not required to maintain a Healthcare Professions Profile, click next to proceed.

You may NOT change your status through online renewal. For information regarding a status change, please contact the renewal desk at 303-894-7800 or dora_dpo_renewalline@state.co.us.

Click next to proceed.

Review

Please make sure to PRINT THIS SCREEN for your records. To do so, you can click the button in the upper right hand corner of this screen labeled "Print Review". You will not be able to print after you leave this review screen.

Renewal - DR.0018738

Name	Donald Warren Aptekar
Credential	DR.0018738

Fee Details

DR - Legal Defense Fund	$2.00
DR - PDMP Fee	$24.00
DR - Portal Fee	$1.50
DR - Renewal Fee Active	$238.50
DR- Peer Fee	$162.00
	$428.00

Affidavit of Eligibility - Screening Present

AFFIDAVIT OF ELIGIBILITY

1. Do you currently reside in and are you physically present in the United States?
Yes

Affidavit of Eligibility - Screening Doc Change

AFFIDAVIT OF ELIGIBILITY

2. Are you a United States Citizen and the State or Federally issued document, in which you proved your legal status in the United States is still valid **and** has not expired since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

-OR-

Are you Not a United States Citizen, but are lawfully present in the United States **and** your legal status within the United States has not changed **and** the legal documents used to prove lawful presence have not changed since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

If you need to update your lawful presence information, select no and you will be prompted to complete a new Affidavit of Eligibility. Otherwise, if your information has not changed, select yes to move forward.
Yes

DR Renewal Attestation

The below attestations apply to your license's CURRENT status. You may not change your status through online renewal. To change your status, please contact the licensing office at dora_registrations@state.co.us or 303-894-7800.

By renewing my license in INACTIVE status, I attest that:

I understand malpractice insurance is not required for Inactive license holders; however, I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an Active license. I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee. I also understand that if I have not actively practiced medicine for two (2) years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.

By renewing my license in ACTIVE status, I attest that:

- In the past two years I have not abused or excessively used any habit forming drug including, alcohol or any controlled substance, and I have not been diagnosed with or treated for a condition that disturbs my cognition, behavior or motor function which has resulted in an adverse action, a professional disciplinary action, a criminal charge, or an allegation or finding of working impaired, diversion of controlled substances or habit -forming medications (including self-prescribing), sexual contact with a patient, substandard medical practice or patient harm.

OR

In the past two years I have abused or excessively used any habit forming drug including, alcohol or any controlled substance, or I have been diagnosed with or treated for a condition that disturbs my cognition, behavior or motor function

which has resulted in an adverse action, a professional disciplinary action, a criminal charge, or an allegation, or finding of working impaired, diversion of a controlled substance or habit-forming medication (including self-prescribing), sexual contact with a patient, substandard medical practice or patient harm AND I have reported, or will report this information within 30 days to the Colorado Medical Board.

- In the last 2 years, no adverse action has been taken against my license by another licensing agency, a peer review body, a health care institution, a residency or postgraduate training program, a professional or medical society or association, a governmental agency, a law enforcement agency, or a court for acts or conduct which, would constitute grounds for disciplinary or adverse actions pursuant to the Medical Practice Act or its attendant rules. For the purpose of this attestation, an adverse action by a law enforcement agency includes: 1) all felony charges; 2) all misdemeanor charges; or, 3) traffic charges/citations involving alcohol, controlled substances, or any other habit-forming drug.

OR

I have reported, or will report within 30 days, any adverse action to the Board in accordance with the requirements of the Medical Practice Act.

- In the last two years, I have not been diagnosed with or treated for an illness, condition or behavior, that disturbs my cognition, behavior, or motor function that has resulted in conduct which may impair my ability to practice as a physician, safely and competently, such as substance misuse or abuse, bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder.

OR

In the last two years, I have been diagnosed with or treated for an illness, condition or behavior that significantly disturbs my cognition, behavior, or motor function that has resulted in conduct which may impair my ability to practice as a physician, safely and competently, such as substance misuse or abuse, bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder AND:

1) The illness or condition is already known to the Colorado Physician Health Program (“CPHP”) and I have made, or will make known within 30 days, any requisite disclosure to the Board pursuant to section 12-36-118.5 and any attendant regulations; OR

2) I have entered into a Confidential Agreement with the Board. For the purpose of this attestation, “Known to CPHP” means that I have informed CPHP of my condition or use of such substances and I am complying with all of CPHP’s requirements for evaluation, treatment and/or monitoring; OR

3) I have reported, or will report within 30 days, the illness or condition to the Medical Board.

- In the last 2 years, I have not been denied medical liability insurance and no liability insurance coverage has been limited, restricted, or terminated by action of the insurance carrier in this or any other state.

OR

I have reported, or will report within 30 days, any denial or limitation of medical liability coverage to the Board.

- I have established and will continuously maintain professional liability insurance as required by §13-64-301, C.R.S.

Click Next to proceed.

HPPP - DR Introduction

Healthcare Professions Profile

Please be aware that this profile is only for your Physician license. Do not provide information for other license types you hold on this profile. You will be required to complete a profile for every license you hold that is included in the profiling requirement.

All information provided in this profile must be updated within 30 days of any change of information unless your profession's statute says otherwise, or unless the question specifies otherwise.

HPPP GLOBAL - Location of Practice

Location of Practice

49. Are you currently practicing in the healthcare profession associated with this profile?

Yes

HPPP GLOBAL - Location of Practice If Yes

Location of Practice

50. Practice Locations:

Address	City	State	Zip Code	Phone Number
4500 East 9th Suite 700	Denver	Colorado	80220	(303) 399-3315

HPPP - MEDICAL Education and Training

Education and Training

51. School or Education Level:
University of Michigan Medical School

52. Please enter the year your initial Degree was achieved: *Only enter the year in YYYY format*

1973

HPPP GLOBAL - Other Licenses

Other Licenses

53. Have you ever held, or do you currently hold any other licenses in this profession from any other state, country or province?
No

HPPP GLOBAL - Board Certifications

Board Certifications

55. Do you hold any current Board Certifications?
Yes

HPPP - MEDICAL Board Certifications if Yes

Board Certifications

56. Board Certifications:

Certification
Obstetrics and Gynecology

HPPP GLOBAL - Practice Specialties

Practice Specialties

57. Do you have a practice specialty in which you are appropriately trained and actively practicing?
Yes

HPPP - MEDICAL Practice Specialties if Yes

Practice Specialties

58. Practice Specialties:

Specialty
Obstetrics and Gynecology

HPPP GLOBAL - CO Hospital Affiliations

Colorado Hospital Affiliations

59. Do you have a current affiliation or clinical privileges with any Colorado Hospital?
Yes

HPPP GLOBAL - CO Hospital Affiliations if Yes

Colorado Hospital Affiliations

60. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
Rose Medical Center	Admitting Privileges	Denver

HPPP GLOBAL - Other Hospital Affiliations

Other Health Care Facilities and Out of State Hospital Affiliations

61. Do you have a current affiliation with any healthcare facility or a non-Colorado hospital?
No

HPPP GLOBAL - Business Ownership

Business Ownership

63. Do you have a current business ownership interest in any healthcare-related business?
No

HPPP GLOBAL - Employer

Employer

65. Do you have an employer in the profession in which you are licensed or are applying for a license?
Yes

HPPP GLOBAL - Employer if Yes

Employer

66. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
Partners in Women's Health	4500 East Ninth Ave	Denver	Colorado	80220	(303) 399-3315

HPPP GLOBAL - Employment Contracts

Employment Contracts

67. Do you have a contract with any business whose mission relates to healthcare services or products where the value is greater than $5000 annually?

Yes

HPPP GLOBAL - Employment Contracts if Yes

Employment Contracts

68. Employment Contracts:

Entity Name	Length of Contract	Contract Position
Myriad Genetics	2 years	Independent Contractor

HPPP GLOBAL - Disciplinary Actions

Disciplinary Actions

69. Have you ever had public disciplinary action taken against your license by any board or licensing agency in any state or country?

No

HPPP GLOBAL - Restrictions and Suspensions

Restrictions and Suspensions

71. Have you ever entered into any agreement or stipulation to temporarily cease your practice or had a board order issued restricting or suspending your license?

No

HPPP GLOBAL - Healthcare Facility Actions

Healthcare Facility Actions

73. Since September 1, 1990, have you had any final actions resulting in involuntary limitations or probationary status on or reduction, nonrenewal, denial, revocation or suspension of medical staff membership or clinical privileges at a hospital or healthcare facility? You are not required to report a precautionary or administrative suspension unless you resigned your medical staff membership or clinical privileges while the suspension was pending.

No

HPPP GLOBAL - Termination of Employment

Termination of Employment

75. Have you ever been terminated by an employer for a reason that would be considered a violation of your profession's practice law?
No

HPPP GLOBAL - DEA Registration

DEA Registration Surrender

77. Have you ever had to involuntarily surrender your United States Drug Enforcement Agency Administration Registration?
No

HPPP GLOBAL - Convictions

Convictions

80. Since you were issued a license to practice your profession in any state or country, have you had any final criminal conviction(s) or plea arrangement(s) resulting from the commission or alleged commission of a felony or crime of moral turpitude in any jurisdiction?
No

HPPP GLOBAL - Malpractice Claims

Malpractice Claims

82. Since September 1, 1990, have you had any final judgment, entered into a settlement, or paid an arbitration award for malpractice?
Yes

HPPP GLOBAL - Malpractice Claims if Yes

Malpractice Claims

83. Malpractice Claims:

Year	State	Claim Type	Arbitrator, Mediator or Court
2007	Colorado	Settlement	copic
2009	Colorado	Settlement	Copic

HPPP GLOBAL - Malpractice Carrier Refusal

Malpractice Carrier Refusal

84. Have you been denied liability insurance, or has your liability insurance coverage been limited, restricted or terminated by the insurance carrier?
No

HPPP GLOBAL - Optional Narrative

Optional Narrative

86. Optional Narrative:

HPPP GLOBAL - Attestation

Attestation

By submitting this Healthcare Professions Profile to the Division of Professions and Occupations you are attesting that:

- You are the person identified in this profile; or
- You are authorized to submit information on behalf of the person identified in this profile; and
- The information contained herein is true and correct to the best of my knowledge.

87. Submission Date:
03/27/2017

Review

Please make sure to PRINT THIS SCREEN for your records. To do so, you can click the button in the upper right hand corner of this screen labeled "Print Review". You will not be able to print after you leave this review screen.