PAID
$522.00 CK
Ref. 300324

DIV. OF REGISTRATIONS 982
DEC 1'09/ 00013

Division of Registrations
Office of Licensing–Medical
(303) 894-7690 / FAX (303) 894-7693
www.dora.state.co.us/registrations

Application for Original License
PHYSICIAN
Fee: $522

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

APPLICANT INFORMATION

Name: Last: SCHAEFER	First: MEGHAN	Middle: LOUISE
Title: (MD, DO) MD		

Previous Name(s):
You must include a copy of legal name change document.

Social Security Number: * Redacted **Date of Birth** (mm/dd/yy): Redacted **Gender:** ☐ Male ☒ Female

Place of Birth (city and state, or foreign country): Summit, New Jersey

Mailing Address:	PO Box, Street: 2 CAMBRIDGE DRIVE
This is a ☒ *Home* ☐ *Business*	City, State, Zip: WARREN NEW JERSEY

Daytime Telephone Number: (732) 236-7856 **E-mail Address:** Redacted

EDUCATION / TRAINING

List the name and address of the school where your medical degree was received:

Name of School	Location (address and ZIP)	Years Attended (from / to)	Year of Graduation
University of Medicine + Dentistry of New Jersey- New Jersey Medical School	185 South Orange Ave Newark NJ 07103	2002-2006	2006

► If this is an international medical school, please provide the country where the school is physically located: _____

Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs? ☒ YES ☐ NO

► **If YES,** provide information below:

Name of Facility	Specialty	Years Attended (from / to)
UMDNJ - New Jersey Medical School	OBStetricst GYNecology	2006 - present

What is your specialty or specialties? OBStetrics + GYNecology

***Social Security Number Disclosure:** Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's social security number. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support under § 14-14-113 and § 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by § 26-13-107(3)(a)(I)(A), C.R.S.; and reporting disciplinary actions to the National Practitioner Data Bank pursuant to 45 CFR §§ 60.1 et seq., and the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 *et seq.* Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

OFFICE USE ONLY LICENSE NUMBER: 48440 DATE ISSUED: 12/29/09

Ck #457 12/2/09 SP

APPLICANT NAME: Meghan Schaefer

EXAMINATION / CERTIFICATION

List name of licensing exam(s): ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam.

Exam	Location	Date	Result
USMLE Step 1	New Jersey	6/21/2004	Redacted
USMLE Step 2 CK	New Jersey	9/23/2005	
USMLE Step 2 CS	New Jersey	8/23/2005	
USMLE Step 3	New Jersey	10/8/2007	

► If this is an international medical school, please provide the country where the school is physically located: _____

Are you Board certified by either the American Board of Medical Specialties or the American Osteopathic Association? ☐ YES ☒ NO

► **If YES,** list certification information: _____

LICENSING INFORMATION

A. Have you ever been licensed to practice medicine in any state, territory, district, or country? (include temporary licenses and educational permits) ☒ YES ☐ NO

► If YES, provide a complete list of all medical licenses (if needed, attach an additional sheet in the same format):

Type of license	State/Country	License #	Year license issued	Disciplinary action against license?	Is this license current/active?
Medical Doctor	New Jersey, USA	25MA0847830	2008	☐ YES ☒ NO	☒ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

B. Have you ever applied for any type of Colorado health care license prior to this application? ☐ YES ☒ NO

► If YES, provide application types and license information if applicable:

Application type	License #	Month & year license issued

MALPRACTICE INSURANCE CERTIFICATION

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 the insurance memo, 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: D. (see enclosed letter)

APPLICANT NAME: Meghan Schaefer

SCREENING QUESTIONS

1. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic licensing board of any complaint, investigation, or inquiry which is currently pending? ☐ YES ☒ NO
   - ▶ **If YES,** give details below AND request official complaint and/or investigative report be sent directly to the Board from the licensing body, as well as personally submit a narrative regarding the complaint.

Agency	Date	Charge	Disposition

2. Has any healing arts license which you now hold or have ever held 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 healthcare 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? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question. ☐ YES ☒ NO
   - ▶ **If YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board, as well as a narrative regarding the action taken.

Agency	Date	Charge	Disposition

3. Have you ever entered into any agreement with any state, territory, district, country, U.S. government agency, and state medical/osteopathic board regarding your medical license? ☐ YES ☒ NO
   - ▶ **If YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason

4. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination in any state, country, or U.S. federal jurisdiction? ☐ YES ☒ NO
   - ▶ **If YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason for Denial

5. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in any other state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. ☐ YES ☒ NO
   - ▶ **If YES,** summarize below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason

APPLICANT NAME: Meghan Schaefer

6. Have either your medical staff membership or clinical privileges at any hospital or healthcare facility or your DEA registration been voluntarily or involuntarily reduced, limited, placed on probation, not renewed or relinquished or have either been denied, revoked or suspended? You must answer YES if any of these actions are currently pending. You must answer YES if you have withdrawn or failed to proceed with an application for these items. ☐ YES ☒ NO

   ► **If YES,** summarize below AND request hospital or DEA to submit a report directly to the Board regarding the action. Also submit your narrative regarding the action taken.

Name of Facility	Date	Reason for Action

7. 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 ☒ NO

   ► **If YES,** summarize below AND submit your narrative regarding the incident as well as court and police records and information regarding final disposition of the case.

Date	Court	Violation	Penalty or Disposition

Redacted

8. 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?
   - Had any change in a condition described above that might affect your ability to practice medicine safely and competently?
   - Illegally or excessively used any controlled substance, habit-forming drug, prescription medication or alcohol?
   - Been diagnosed with or treated for bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness or sleep disorder that disturbs your cognition, behavior or motor function?

   You may answer NO if the behavior or condition is already known to the Colorado Physician Health Program (CPHP). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

   ► **If YES** *, submit explanation to the Board regarding the diagnosis or disorder(s). Be specific as to date of occurrences, the type of disorder involved, and what if anything has been done to treat the disorder. Please submit copies of any discharge summaries, evaluations, reports, DUI or DWAI records, police reports, and court records directly to the Board.

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* ***Please be advised that an affirmative response to Question #8 oftentimes triggers a request from the Board for evaluation by the Colorado Physician Health Program (CPHP). The CPHP evaluation process could potentially delay consideration of an application.*** *Therefore, the Board is providing advance notice of this possibility so that applicants may contact CPHP to schedule an evaluation at the beginning of the application process. By doing so, the application for licensure should not be unduly delayed. An applicant is not required to contact CPHP in advance of Board consideration of the application. The applicant may choose to wait for a specific decision by the Board that a CPHP evaluation is necessary. This information is being provided to put applicants on notice with respect to this potential requirement and afford the applicant the opportunity to expedite the process if he or she so desires. (Colorado Physicians Health Program – CPHP, 899 Logan Street, #410, Denver, CO 80203; 303-860-0122.)*

The following conditions oftentimes trigger a request for CPHP evaluation:

- *Substance abuse or dependence, including any relapses, within the past five years.*
- *Any Axis I, DSM IV diagnosis including, but not limited to, bipolar disorder or schizophrenia.*
- *Any physical condition requiring use of special equipment or facilities or any other accommodation. Such accommodation includes a reduction in the number of hours worked. Such conditions may include, but are not limited to, multiple sclerosis, neurological disorders or loss of the use of arms or legs.*
- *Deficiencies in vision or hearing, which cannot be corrected with glasses, contact lenses or hearing aids.*

It is the intent of the Board that a condition of the type listed above would necessitate a YES answer.

APPLICANT NAME: Meghan Schaefer

9. 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 ☒ NO
   - ► **If YES,** summarize below AND submit to the Board a completed malpractice Claims Information Form (attached) and a clinical narrative regarding your involvement in the case.

Date	Name and Address of Insurance Company	Reason for Action

10. 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 ☒ NO
    - ► **If YES,** submit to the Board an explanation regarding the cancellation or increase in premiums of the insurance and verification directly from the insurance company to the Board.

ATTESTATION

I 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), which includes state medical licensing boards and the Federation of State Medical Boards, to release to the licensing Board any information, files or records requested by the Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine during the processing of this application and the time that I am a licensee of this Board.

I state under penalty of perjury in the second degree, as defined in 18-8-503, C.R.S. that the information contained in this application is true and correct to the best of my knowledge. In accordance with 18-8-501(2)(a)(I), C.R.S. false statements made herein are punishable by law and may constitute violation of the practice act.

Meghan Schaefer
Signature of Applicant

11/12/2009
Date

Colorado Division of Registrations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303) 894-7690 / FAX: (303) 894-7693
www.dora.state.co.us/registrations

REPORT OF PRACTICE HISTORY

(by month and year from medical school to the present – refer to instructions on following page)

Facility Name	Address and Zip	Reference (name and title)	Dates of Practice From-To	Nature of Practice
1. UMDNJ-University Hospital-NJ Medical School	185 South Orange Ave Room E506 Newark, NJ 07103 (medical science building)	JACQUELINE LOUGHLIN Residency Program Director	JULY 2006 to present	OB/GYN resident
2.				
3.				
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.

M Schaefer — Signature
SCHAEFER — Print Last Name
11/12/09 — Date

L6

DEC 4 2009

DIVISION OF REGISTRATIONS
2

Colorado Division of Registrations
Office of Licensing—Medical
1560 Broadway, Suite 1350
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CERTIFICATE OF MEDICAL EDUCATION

SECTION 1

To be completed by applicant and forwarded to school where medical degree was received.

This certifies that Meghan Louise Schaefer
Full Name of Applicant

enrolled in UMDNJ- New Jersey Medical School
Full Name of School

Newark New Jersey on the 12 Day day of August Month, 2002 Year.
Location of School

SECTION 2

To be completed by president / secretary / dean of medical school and forwarded to the Office of Licensing.

The undersigned certifies that the records of this institution show that s/he attended this institution

beginning on the 12 Day day of August Month, 2002 Year and was granted the degree

Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 24 Day day of May Month, 06 Year.

Signed and the college seal affixed

This 1 Day day of December Month, 2009 Year.

By Julie E. Ferguson
President / Secretary / Dean

Julie E. Ferguson, MPA
Asst. Dean for Student Affairs / Registrar

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:
If no school seal, please indicate above next to signature of President/Secretary/Dean.

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DIV. OF REGISTRATIONS 984
DEC 7'09/ 00337

Colorado Division of Registrations
Office of Licensing—Medical
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Denver, CO 80202
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CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

SECTION 1

To be completed by applicant and forwarded to the facility where postgraduate training was received and/or completed.

This certifies that Meghan Louise Schaefer
Full Name of Applicant

a graduate of UMDNJ-New Jersey MEdical School
Full Name of Medical/Osteopathic School

commenced postgraduate training at UMDNJ-New Jersey Medical School, Dept. of Ob/Gyn & Women's Health
185 S. Orange Avenue, E506, Newark, NJ 07103
Name and Address of Facility

SECTION 2

To be completed by the program director of the facility for ACGME/AOA postgraduate training in the United States or Canada.

on July 1, 2006 and satisfactorily completed or will complete such training on June 30, 2010.

This training consisted of 48 months of actual clinical instruction and is approved by the Accredited Council for 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. 4 YEAR OB/GYN RESIDENCY TRAINING PROGRAM

ROTATION	LENGTH OF ROTATION

Redacted

Was this physician's performance completely satisfactory?

▶If NO, please attach an explanation.

I hereby declare under penalty of perjury under the laws of the State of Colorado that the information provided in this certificate is 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 Jacquelyn S. Loughlin, MD

Address UMDNJ-NJMS, 185 S. Orange Ave, E506, Newark, NJ 07103

Phone Number 973-972-5266 Date 12/3/09

Signature Jacquelyn S. Loughlin

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FEDERATION OF STATE MEDICAL BOARDS
DISCIPLINARY ACTION REPORT

PHYSICIAN

PLEASE COMPLETE ALL BLANKS ON THIS FORM AND MAIL DIRECTLY TO:

Federation of State Medical Boards
PO Box 619850
Dallas, TX 75261-9850

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

Name: Meghan Schaefer

Address: 2 Cambridge Drive

City, State, Zip Code: Warren New Jersey 07059

Date of Birth: Redacted

Social Security Number: Redacted

Medical School: University of Medicine+Dentistry of New Jersey - NJ Medical School

Date of Graduation: MAY 24, 2006

I hereby authorize and request that the Federation of State Medical Boards of the United States, Inc. provide a disciplinary history to the following:

Colorado Division of Registrations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

DEC 02 2009

THE FEDERATION PHYSICIAN
DATA CENTER

Meghan Schaefer
Signature

11/12/09
Date

To complete your application we must have a report from the Federation's National Databank of disciplinary actions taken by state licensing boards and/or other credentialing agencies. Please note: an unfavorable report does not automatically disqualify you from licensure in Colorado.

*** NO FEE REQUIRED ***

November 21st, 2009

Dear Colorado State Board of Medical Examiners,

I currently reside outside of Colorado, and claim exemption D set forth in the attached rule. I understand that before I engage in any medical practice in Colorado I must obtain the required insurance or an acceptable equivalent.

Sincerely,

Meghan Schaefer MD.

Meghan Schaefer

Colorado Department of Regulatory Agencies
Division of Registrations
1560 Broadway, Suite 1350
Denver, CO 80202

AFFIDAVIT OF ELIGIBILITY

Pursuant to H.B. 06S-1009, C.R.S 24-34-107, ALL applicants for original licensure or licensees renewing a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) Meghan Schaefer, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check 1, 2 or 3 below):

1. X I am a US citizen.

2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
   a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641.
   b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended.
   c. ___ I am an alien who is paroled into the US under 8 U.S.C. sec. 1182 (d) (5).

3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
   a. ___ I am a US citizen, not physically present or employed in the United States.
   b. ___ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided upon request only.

   - ☐ Any Colorado Driver License, Colorado Driver Permit or Colorado Identification Card, expired less than one year. (Temporary paper license with invalid Colorado Driver License, Colorado Driver Permit, or Colorado Identification Card, expired less than one year is considered acceptable.)
   - ☒ Out-of-state issued photo Driver's License or photo identification card, photo driver's permit expired less than one year.
   - ☐ Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa.
   - ☐ Valid I-551 Resident Alien or Permanent Resident card.
   - ☐ Valid foreign passport accompanied by an "I-94" indicating a specific future "until" date.
   - ☐ Valid I-94 issued by Canadian government with L1 or R1 status and a valid Canadian driver's license or valid Canadian identification card.
   - ☐ Valid Temporary Resident Card.
   - ☐ Valid I-94 with refugee/asylum stamp.

(document list continued on page 2)

- ☐ Valid 1688B or 1766 Employment Authorization Card.
- ☐ Valid US Military ID (active duty, dependent, retired, reserve and National Guard).
- ☐ Tribal Identification Card with intact photo (US or Canadian).
- ☐ Certificate of Naturalization with intact photo.
- ☐ Certificate of (US) Citizenship with intact photo.
- ☐ Passport issued by the U.S. Government with one of the following documents: Social Security card; marriage, divorce or separation certificate or decree; or a Colorado or Federal tax return.
- ☐ Colorado Department of Corrections Inmate Identification Card with a Social Security card issued by the United States Government.

2. Enter the state or the federal agency name where this secure and verifiable document was issued.
New Jersey Division of Motor Vehicles / Motor vehicle commission
(If issued by a state agency, include both the state and agency name.)

3. What is the secure and verifiable document number? S1301537735280 4

4. What is the expiration date of your secure and verifiable document? 02 / 28 / 2013 (month/day/year)
(If you hold a document without an expiration date, such as a military ID or naturalization certificate, write N/A.)

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 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified above 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 above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Meghan Schaefer
Signature

11/12/09
Date

Meghan L Schaefer
Please print your name as shown on your secure and verifiable document.

Professional License Type: Medical Doctor

License Number (if already licensed): _____

Lookup Detail View

Licensee Information

This serves as primary source verification of the license.*

**Primary source verification: License information provided by the Colorado Division of Professions and Occupations, established by 24-34-102 C.R.S.*

Name	Public Address
Meghan Louise Schaefer	2 Dean Dr Tenafly, NJ 07670

Credential Information

License Number	License Method	License Type	License Status	Original Issue Date	Effective Date	Expiration Date
DR.0048440	Original	Physician	Expired	12/29/2009	06/01/2011	04/30/2013

Board/Program Actions

Discipline
There is no Discipline or Board Actions on file for this credential.

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