PAID
412.00
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Division of Professions and Occupations
Office of Licensing–Medical
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7800 / Fax (303) 894-7693
www.dora.colorado.gov/professions

DPO FRONT DESK

Application for Original License
PHYSICIAN
Fee: $412

Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to State of Colorado.

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.

9/7/17

PART 1—APPLICANT INFORMATION

Name: First: Angela	Middle: Lynn	Last: Marchin	☒ MD ☐ DO
Previous Name(s):			
Social Security Number: * Redacted			
E-mail Address: Redacted *(This will be the pri...)*			
Mailing Address: *This is a* ☒ *Home* ☐ *Business*	PO Box, Street: 1147 Carbone Dr.		
	City, State, Zip: Columbus, OH 43224		
Daytime Telephone Number: (586) 764-7201	**Date of Birth** (mm/dd/yyyy): Redacted		
Place of Birth (city and state, or foreign country): Warren, MI	**Gender:** ☐ *Male* ☒ *Female*		

JAN302017/00016

PART 2—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
Michigan State University College of Human Medicine	15 Michigan St. NE Grand Rapids, MI 49503	2009-2013	2013

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

*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 Sections 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 Section 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the National Practitioner Data Bank pursuant to 45 CFR Sections 60.1 et seq., and the Health Integrity and Protection Data Bank as required by 45 CFR Sections 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:** 59317 **DATE ISSUED:** 4/4/17

APPLICANT NAME: Angela Marchin

PART 2—EDUCATION / TRAINING (Continued)

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)
The Ohio State/Mt. Carmel Health	OB/Gyn	2013 - 2017

What is your specialty or specialties? Obstetrics + Gynecology

PART 3—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	Lansing, MI	15 Jun 2011	Redacted
USMLE STEP 2 CK	Lansing, MI	22 Oct 2012	
USMLE STEP 2 CS	Atlanta, GA	24 Oct 2012	
USMLE STEP 3	~~Columbus, OH~~ Worthington, OH	4 Mar 2015	

► 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: _____

PART 4—LICENSE 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 Number	Year license issued	Disciplinary action against license?	Is this license current/active?
MD Training Certificate	Ohio / United States	57.023815	2013	☐ 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 Number	Month and year license issued

APPLICANT NAME: Angela Marchin

PART 5—MALPRACTICE INSURANCE CERTIFICATION

You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado law, or claim one of the 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: Exemption D

PART 6—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

APPLICANT NAME: Angela Marchin

PART 6—SCREENING QUESTIONS (Continued)

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

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: 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

8. Do you now abuse or excessively use, or have you in the last five 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?

9. In the last five 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 including but not limited to bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder?

Redacted

You may answer NO to Question 8 or 9 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 you answer YES to Question 8 or 9, submit detailed information to the Board that will allow the Board to assess your ability to practice safely, competently, and without impairment to your professional judgment, skill, or knowledge. In addition to that information, you are required to provide copies of any related records, reports, evaluations, police reports, probation reports, and court records directly to the Board.

APPLICANT NAME: Angela Marchin

PART 6—SCREENING QUESTIONS (Continued)

Please be advised that an affirmative response to Question 8 or 9 *may result in* 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.)

10. 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

11. 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.

PART 7—MILITARY

Are you a Member of the U.S. military? ☐ YES ☒ NO

- ➢ If **YES**, provide information below:

Branch:	Duty Station:

PART 8—SECURITY OF PATIENT MEDICAL RECORDS

☒ By checking this box, I attest that I have developed a written plan to ensure the security of patient medical records in compliance with § 12-36-140, C.R.S.

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.

Angela Marchin — **Signature of Applicant**

1/11/2017 — **Date**

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REPORT OF PRACTICE HISTORY

(See instructions on following page)

	Dates of Practice From mm/yyyy	To mm/yyyy	Facility Name	Address (Street & Number, City, State, ZIP)	Reference (Name and Title)	Nature of Practice
1	07/2013	06/2017	The Ohio State/Mt. Carmel Health OB/GYN residency program	5th Floor 395 West 12th Ave Columbus, OH 43210	Philip Samuels Program Director	OB/GYN Residency
2						
3						
4						
5						
6						
7						
8						
9						
10						

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, C.R.S., 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.

Applicant Signature | Marchin Applicant Last Name (print) | 1/11/2017 Date

10/2015

L6

DPD 947

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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 Angela Marchin
(Full Name of Applicant)

enrolled in Michigan State University College of Human Medicine
(Full Name of School)

East Lansing, MI (Location of School) on the 31 (Day) day of August (Month), 2009 (Year).

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 31 (Day) day of August (Month), 2009 (Year) and was granted the degree

Bachelor/(Doctor of Medicine) or Doctor of Osteopathy on the 3 (Day) day of May (Month), 2013 (Year)

Signed and the college seal affixed

This 22 (Day) day of January (Month), 2017 (Year).

By Sherrie Zimmerman
President / (Secretary) / Dean

NOT VALID WITHOUT SCHOOL SEAL

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

L2

DPO 993

JAN31'17/000330

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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 Angela Marchin
Full Name of Applicant

a graduate of Michigan State University College of Human Medicine
Full Name of Medical/Osteopathic School

commenced postgraduate training at The Ohio State/Mt Carmel Health 5th Floor 395 West 12th Ave Columbus, OH 43210
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, 2013 and satisfactorily completed or will complete such training on June 30, 2017

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.

ROTATION	LENGTH OF ROTATION
Obstetrics and Gynecology Residency	4 years

Was this physician's performance completely satisfactory?

Redacted

►**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 Philip Samuels, MD

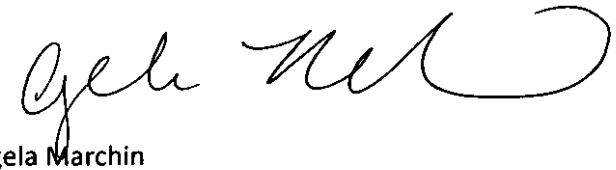
Address 395 W. 12th Avenue Room 510 Columbus, Ohio 43210

Phone Number 614-293-86946 Date 1/19/17

Signature Philip Samuels MD

L3

I currently reside outside of Colorado, and claim exemption D set forth in Rule 220. I understand that before I engage in any medical practice in Colorado, I must obtain the required insurance or an acceptable equivalent.



Angela Marchin

Colorado Department of Regulatory Agencies
Division of Professions and Occupations
1560 Broadway, Suite 1350
Denver, CO 80202

Licensee/Applicant Full Legal Name

Last	First	Middle	Suffix
Marchin	Angela	Lynn	

Colorado Professional or Occupational License/Certification/Registration Number: N/A
(if already licensed)

Professional or Occupational License/Certification/Registration type applying for: Medical

AFFIDAVIT OF ELIGIBILITY

Pursuant to H.B. 06S-1009, 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.*

Section A: LAWFUL PRESENCE in the United States

1. ☒ I am a U.S. citizen. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
2. ☐ I am not a U.S. citizen, but I am lawfully present in the U.S. and authorized by the Department of Homeland Security to be employed in the U.S. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
3. ☐ I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.)
   a. ☐ I am a U.S. 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.

Section B: SECURE AND VERIFIABLE DOCUMENTS
Select ONE document in this section if you checked 1 or 2 in Section A.

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
☒ Driver's license or permit	Ohio Bureau of Motor Vehicles	Angela Marchin	UR603317	09/01/2019
☐ Government issued ID card				
☐ Valid U.S. military ID/common access card				
☐ Colorado Department of Corrections inmate ID				
☐ Tribal ID card				
☐ U.S. passport				
☐ Certificate of Naturalization				

Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
☐ Certificate of (U.S.) Citizenship				
☐ Valid Temporary Resident card				
☐ Valid I-94 issued by Canadian government				
☐ Valid I-94 with refugee/asylum stamp				

☐ Valid I-766 (Employment Authorization Card) — **Issuing federal agency:**

Name on card	Alien Number (A#)	Card Number	Valid from (mm/dd/yyyy)	Expires (mm/dd/yyyy)

☐ Valid I-551 (Resident Alien or Permanent Resident Card) — **Issuing federal agency:**

Name on card	Alien Number (A#)	Country of birth	Card expires (mm/dd/yyyy)	Resident since (mm/dd/yyyy)

☐ Valid foreign passport with an unexpired visa with proper classification for work authorization, and an unexpired I-94

Issuing foreign country	Passport Number	Visa Number	Visa Class (ex.: J-1, P-1, H-1B, etc.)	Date of entry (mm/dd/yyyy)	Until date (mm/dd/yyyy)

☐ Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa

Issuing foreign country:	Passport Number:

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.

Angela Lynn Marchin
Print Full Legal Name


Signature (Full Name)

11/11/2017
Date

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
Angela Lynn Marchin	Columbus, OH 43224-2015

License Information

Some Physician Licensees have converted their Active Physician license to an Active Compact Physician License. This is noted below by the status label: Transferred to Compact Physician. If this status is present, then you may verify the license by searching for the license using the prefix "CDRH" and the Licensees Name on our Online Services page (https://apps.colorado.gov/dora/licensing/Lookup/LicenseLookup.aspx).

License Number	License Method	License Type	License Status	Original Issue Date	Effective Date	Expiration Date
DR.0058317	Original	Physician	Active	04/04/2017	04/04/2017	04/30/2019

Board/Program Actions

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

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