STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
Susan Miller, Program Administrator

1560 Broadway, Suite 1300
Denver, Colorado 80202-5146
Phone (303) 894-7690
Fax (303) 894-7692
V/TDD (303) 894-7880
www.dora.state.co.us/medical

Department of Regulatory Agencies
M. Michael Cooke
Executive Director

Division of Registrations
Rosemary McCool
Director

Bill Owens
Governor

October 30, 2002

Kristina B. Fraser, M.D.
364 S. Vine St.
Denver CO 80209

Dear Dr. Fraser:

The Colorado Board of Medical Examiners has approved your application for a license to practice medicine in the State of Colorado.

Your license number is 40987, effective October 15, 2002, and will expire May 31, 2003. Your license will follow under separate cover.

All Colorado medical licenses will lapse May 31 of each uneven-numbered year. A renewal notice will be mailed approximately two months prior to your expiration date, to the last known address of record with the Board. It is your legal obligation to keep this office informed of your address at all times so that you are in compliance with the Colorado Medical Practice Law, that our files may be accurate and that future communications reach you without delay. Failure to renew your license will automatically suspend your license and your right to practice as a Physician in the State of Colorado.

Enclosed you will find a customer satisfaction survey. Please take a few minutes to complete and return it to us. We value your response and will use your comments to evaluate our procedures and requirements.

If you have any questions, please contact this office.

Sincerely,
FOR THE COLORADO BOARD OF MEDICAL EXAMINERS

Jean Brown

Jean Brown
Administrative Assistant

APD 9102

COLORADO STATE BOARD OF MEDICAL EXAMINERS

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

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

1 a. Name: Last First Middle Degree

FRASER, KRISTINA BARBARA MD

1b. Social Security Number: Redacted

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

NONE

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

☒ Home ☐ Business 364 SOUTH VINE STREET

City: DENVER State: CO Zip: 80209 Country: USA

e-mail address: Redacted

4. Telephone Number: (Area Code) Day: (303) 744 · 3372 Evening: DAY + EVENING

5. Date of Birth: Mo/Day/Year: Redacted Place of Birth: ENGLEWOOD, NJ

6. Sex: Male (Female)

7. Have you ever filed an application in Colorado?
☒ Yes ☐ No If yes, give date of previous application: 7/2002 FOR PHYSICIAN TRAINING LISCENCE

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

Name of School	Address and Zip	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
University of Colorado	4200 East 9th Ave Denver CO 80262	08/1995	05/1999

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

Exam	Location	Date	Result
USMLE STEP #1	Denver, CO	06/1997	236
USMLE STEP #2	Denver, CO	08/1998	226
USMLE STEP #3	Boulder, CO	09/2000	213

Redacted

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

Name of facility	Specialty	Period of attendance From (Mo/Yr)	To (Mo/Yr)
University of Colorado	Obstetrics and Gynecology	06/1999	Present
			Anticipated Completion 06/30/2003

#409871 10-15-2002 L1A

Official Use Only	License #	Date
Revised 10/99	Fee $ 425.	Date 9-30-02

11. Are you now or have you ever been licensed to practice medicine in any state, territory, district or country? Include temporary licenses and educational permits. Request verification from each to be sent to the Colorado Board.

☒ **Yes** If yes, provide information below.

☐ **No**

State or country	License #	Dates of Practice in this jurisdiction	
		Issue Date	Expiration Date
State of Colorado	#40	08/07/2002	08/31/2005
	This is a training liscence		

12. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic board of *any complaint, investigation or inquiry, which is* ***currently pending?***

☐ **Yes** If yes, give details below.

☒ **No**

State	Date	Charge	Disposition

13. Has **any disciplinary action** ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity? (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question.

☐ **Yes** *If yes, give details below.*

☒ **No**

State	Date	Charge	Disposition

14. Have you ever entered into any agreement with any state, territory, district, country, US government agency, and state medical/osteopathic board regarding your medical license?

☐ **Yes** If yes, give details below:

☒ **No**

Agency	Date	Reason

15. 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 US federal jurisdiction?

☐ **Yes** If yes, give details below:

☒ **No**

Agency	Date	Reason for denial

16. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in any state country or U.S. federal jurisdiction? This does not include allowing your license to lapse solely due to non-payment of the renewal fee.

☐ **Yes** *If yes, explain on a separate sheet, summarize below:*

☒ **No**

Agency	Date	Reason

2002-10-15 7:18 pm

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

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

☒ **No**

Name of facility	Date	Reason for action

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

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

☒ **No**

Date	Court	Violation	Penalty or disposition

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

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

No

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

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

No

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

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

No

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

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

☒ **No**

Date	Name and address of Insurance Company	Reason for Action

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

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

☒ **No**

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

EXEMPTION CLAIMED: Note: Graduate Medical Education office at the University of Colorado is sending documentation to the State Board

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

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

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

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

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

Kristina B. Fraser
Signature

9/9/2002
Date

RETURN THIS APPLICATION TO:

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

L1D

STATE OF COLORADO

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

SEP 25 2002

BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Kristina Barbara Fraser
FULL NAME OF APPLICANT

enrolled in University of Colorado
FULL NAME OF MEDICAL SCHOOL

Denver, Colorado on the 28th day of August 1995
LOCATION OF MEDICAL SCHOOL

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

The undersigned certifies that the records of this institution show that he/she attended this institution beginning on the 28th day of August, 1995 and was granted the degree Bachelor/(Doctor of Medicine) or Doctor of Osteopathy on the 29th day of May, 1999.

Signed and the college seal affixed

This 23rd day of September, 2002

By Rhianna Lee McClaren, UCHSC Registrar's Office

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

L2

STATE OF COLORADO

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

SEP 27 2002

BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

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

This certifies that Kristina Barbara Fraser
FULL NAME OF APPLICANT

a graduate of University of Colorado Health Sciences Center (Medical School)
FULL NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in Obstetrics and Gynecology at
NAME AND ADDRESS OF FACILITY
University of Colorado Health Sciences Center

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

on June 23, 1999 and satisfactorily completes such training on June 30, 2003.

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

List type and length of training.

ROTATION	LENGTH OF ROTATION
OB/Gyn	—

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

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 Kirsten J. Lund, MD.

ADDRESS UCHSC, 4200 E. 9th Ave, B-198, Denver, CO 80262

PHONE NUMBER (303) 315-3169 DATE 9/24/02

SIGNATURE X

L3

STATE OF COLORADO

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

SEP 30 [illegible]
BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

REPORT OF PRACTICE HISTORY

Facility Name	Address and Zip	Reference (name and title)	Dates of Practice From-To	Nature of Practice
1. University of Colorado Health Sciences Center	4200 East 9th Ave Denver CO 80262	Kirsten J. Lund Obstetrics + Gynecology Residency Program Director	6/23/1999 to Present	Obstetrics + Gynecology Residency
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.

Kristina B. Fraser — SIGNATURE

FRASER — PRINT LAST NAME

9/9/2002 — DATE

L6

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

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

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

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

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

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

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

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

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

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

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

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

STATE OF COLORADO

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

Department of Regulatory Agencies
Division of Registrations

DISCIPLINARY ACTION REPORT

PLEASE COMPLETE ALL BLANKS ON THIS FORM AND MAIL TO:

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

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

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

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

OCT - 4 2002

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

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

NAME Kristina Barbara Fraser
ADDRESS 364 South Vine Street
CITY, STATE AND ZIP CODE Denver Colorado 80209
DATE OF BIRTH Redacted
SOCIAL SECURITY NUMBER Redacted
MEDICAL SCHOOL University of Colorado
DATE OF GRADUATION 05/29/1999

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

Kristina B. Fraser
Signature

09/09/2002
Date

L7

University of Colorado Health Sciences Center

Graduate Medical Education
School of Medicine
4200 East Ninth Avenue, C293
Denver, Colorado 80262
Phone 303-315-7424
Fax 303-315-7399

CONFIRMATION OF MALPRACTICE COVERAGE

The University of Colorado Health Sciences Center provides medical malpractice coverage for its employees, students and volunteers through a combination of self-insurance and commercial insurance. This coverage is subject to the terms of the University of Colorado Self-Insurance and Risk Management Trust Coverage Document. Coverage extends to injuries arising from acts or omissions occurring during the performance of the covered person's duties and within the scope of the covered person's duties and within the scope of the covered person's employment or training, unless the act or omission was willful and wanton.

The Trust's coverage extends to employees, students and volunteers defined in the Trust Coverage Document and in accordance with the Colorado Governmental Immunity Act (C. R. S. 24-10-101 et. seq.). These employees, students and volunteers are considered to be "public employees" under the Colorado Governmental Immunity Act and their liability is limited by the Act as follows:

(a) for any injury to one person in any single occurrence, the sum of $150,000;
(b) for any injury to two or more persons in any single occurrence, the sum of $600,000; except in such instance, no person may recover in excess of $150,000.

For claims subject to the protection of the Colorado Governmental Immunity Act, if a court of competent jurisdiction rules as a final judgment that the limitations of the Act are not applicable to the University, the University of Colorado Hospital, a particular public employee, faculty member or student, then the Trust provides **secondary** coverage through a commercial policy which has limits of at least $1,000,000 per occurrence and $3,000,000 in aggregate.

All inquiries regarding the coverage provided or claims history for the individual named below should be directed to the Office of Professional Risk Management, 4200 E. 9th Ave., A-039, Denver, Colorado 80262.

Carol M. Rumack, MD/cj
Carol M. Rumack, M.D./Designee
Associate Dean
Graduate Medical Education

Today's Date:	September 24, 2002	Date program began:	June 23, 1999
Houseofficer's name:	Kristina Fraser, MD	Date program end:	June 30, 2003

Renewal - DR.0040987

Name	Kristina Barbara Fraser
Credential	DR.0040987

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 HPPP

Healthcare Professions Profiling Program ACTIVE status only:

All ACTIVE status licensees must maintain a Healthcare Professions Profile with current information. Please note that licensees are required to update their Healthcare Professions Profile within 30 days of changes or any reportable events. To access your HPPP account, please go to the HPPP Database by CLICKING HERE and enter your Login ID and Password for the HPPP system - these may be different from your User ID and password for this account in the Online Services system. Remember, it is your respons bility to maintain the accuracy of your Healthcare Profile within 30 days of any change. Failure to timely update your database may subject your license to disciplinary action.

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.

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.

No

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.

Redac

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.

Redac

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.

D. I maintain commercial professional liability insurance with a company other than those listed in A, B, or C above that is authorized to do business in Colorado, in minimum indemnity amounts of at least $1,000,000 per incident and $3,000,000 annual aggregate per year. Please submit an e-mail with the name of that company to **DORA_MedicalBoard@state.co.us**.

KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

Review

Renewal - DR.0040987

Name	Kristina Barbara Fraser
Credential	DR.0040987

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.0040987

Name	Kristina Barbara Fraser
Credential	DR.0040987

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
	Denver	Colorado	80209	
Rose Medical Center	Denver	Colorado	80220	(303) 320-2435

HPPP - MEDICAL Education and Training

Education and Training

51. School or Education Level:
University of Colorado School of Medicine

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

1999

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
Questcare Obstetrics	12221 Merit Drive Suite 1610	Dallas	Texas	75251	(800) 369-8397

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?

No

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?
No

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:
03/26/2017

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.

Renewal - DR.0040987

Name	Kristina Barbara Fraser
Credential	DR.0040987

Fee Details

DR - Legal Defense Fund	$2.00
DR - PDMP Fee	$24.00
DR - Portal Fee	$1.50
DR - Renewal Fee Active	$218.50
DR- Peer Fee	$140.00
	$386.00

DR Renewal Attestation

The below attestations apply to your license's CURRENT status. You CANNOT 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. DR have Active and Inactive options, CDRH has Active only

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 engaged in any conduct or exhibited any behaviors that resulted in the following following OR that I have reported, or will report this information within 30 days to the Colorado Medical Board at dora_medicalboard@state.co.us or 303-894-7690.:

- An arrest, discipline, sanction or warning
- Loss or suspension of any license
- Termination or suspension of any license
- Endangering the safety of others
- A breach of fiduciary obligations
- A violation of workplace or academic conduct rules
- An impairment of your ability to practice in a safe, competent, ethical and professional manner
- Abusing or excessively using any habit forming drug, including alcohol, or any illegal or controlled substance resulting in any discipline for misconduct, failure to meet professional responsibilities, or affecting your ability to practice safely and competently
- Claiming the illegal use of a substance as a defense, in mitigation, or as an explanation for any conduct that impairs your ability to practice in a safe, competent, ethical, and professional manner

By renewing my license in ACTIVE status, I attest that I have NOT had an adverse action or administrative/judicial proceeding and I do not have a pending inquiry or investigation within the last two years by the following OR that I have reported, or will report this information within 30 days to the Colorado Medical Board at dora_medicalboard@state.co.us or 303-894-7690:

- A licensing authority - other than the Colorado Medical Board
- A government agency
- A court
- An employer
- An educational institution
- A professional organization
- In connection with an employment disciplinary or termination procedure

By renewing my license in ACTIVE status, I attest that: I have established and will continuously maintain professional liability insurance as required by 13-64-301, C.R.S.

All statuses click Next to proceed.

PDMP Renewal Attestation

By renewing your license in Active status, you agree with the following statement:

I attest that IF I maintain a current United States Drug Enforcement Agency (DEA) registration, I have registered an individual user account with Colorado's Prescription Drug Monitoring Program (PDMP) at https://colorado.pmpaware.net.

(If you have questions about registering or to check if you have registered, please email the PDMP Help Desk at pdmpinqr@state.co.us for assistance.)

Click Next to proceed.

AoE Renewal Update

Affidavit of Eligibility | Renewal Update of Information

1. Since you were originally licensed or since your last renewal (whichever was more recent) has the documentation you provided proving your legal status in the United States changed?

- If nothing has changed in your legal status or documentation, select "No"
- If your status has changed, or you need to update your documentation, select "Yes" to update your information

No

AoE Attestation

Affidavit of Eligibility | Section C: Attestation

By submitting this Affidavit of Eligibility (AoE) you are attesting that you have read and understand the statements below:

- 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 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.

96. Please enter today's date below:

03/27/2019

Healthcare Profile - Physician Introduction

Healthcare Professions Profile | Introduction

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.

Healthcare Profile - Location of Practice

Healthcare Professions Profile | Location of Practice

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

Yes

Healthcare Profile - Location of Practice if Yes

Healthcare Professions Profile | Location of Practice

98. Practice Locations:

Address	City	State	Zip Code	Phone Number
	Denver	Colorado	80209	
Rose Medical Center	Denver	Colorado	80220	(303) 320-2435

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

99. School or Education Level:
University of Colorado School of Medicine

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

1999

Healthcare Profile - Other Licenses

Healthcare Professions Profile | Other Licenses

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

Healthcare Profile - Board Certifications

Healthcare Professions Profile | Board Certifications

103. Do you hold any current Board Certifications?
Yes

Healthcare Profile - Medical Board Certifications if Yes

Healthcare Professions Profile | Board Certifications

104. Board Certifications:

Certification
Obstetrics and Gynecology

Healthcare Profile - Practice Specialties

Healthcare Professions Profile | Practice Specialties

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

Healthcare Profile - Medical Practice Specialties if Yes

Healthcare Professions Profile | Practice Specialties

106. Practice Specialties:

Specialty
Obstetrics and Gynecology

Healthcare Profile - Colorado Hospital Affiliations

Healthcare Professions Profile | Colorado Hospital Affiliations

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

Healthcare Profile - Colorado Hospital Affiliations if Yes

Healthcare Professions Profile | Colorado Hospital Affiliations

108. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
Rose Medical Center	Admitting Privileges	Denver
Penrose-St. Francis Health Services	Admitting Privileges	Colorado Springs

Healthcare Profile - Other Facility and Out of State Hospital Affiliations

Healthcare Professions Profile | Other Facility and Out of State Hospital Affiliations

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

Healthcare Profile - Business Ownership

Healthcare Professions Profile | Business Ownership

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

Healthcare Profile - Employer

Healthcare Professions Profile | Employer

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

Healthcare Profile - Employer if Yes

Healthcare Professions Profile | Employer

114. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
Questcare Obstetrics	12221 Merit Drive Suite 1610	Dallas	Texas	75251	(800) 369-8397

Healthcare Profile - Employment Contracts

Healthcare Professions Profile | Employment Contracts

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

No

Healthcare Profile - Disciplinary Actions

Healthcare Professions Profile | Disciplinary Actions

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

No

Healthcare Profile - Restrictions and Suspensions

Healthcare Professions Profile | Restrictions and Suspensions

119. 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

Healthcare Profile - Healthcare Facility Actions

Healthcare Professions Profile | Healthcare Facility Actions

121. 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

Healthcare Profile - Termination of Employment

Healthcare Professions Profile | Termination of Employment

123. Have you ever been terminated by an employer for a reason that would be considered a violation of your profession's practice law?

No

Healthcare Profile - DEA Registration

Healthcare Professions Profile | DEA Registration

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

Healthcare Profile - Convictions

Healthcare Professions Profile | Convictions

128. 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

Healthcare Profile - Malpractice Claims

Healthcare Professions Profile | Malpractice Claims

130. Since September 1, 1990, have you had any final judgment, entered into a settlement, or paid an arbitration award for malpractice?
No

Healthcare Profile - Malpractice Carrier Refusal

Healthcare Professions Profile | Malpractice Carrier Refusal

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

Healthcare Profile - Optional Narrative

Healthcare Professions Profile | Optional Narrative

134. Optional Narrative:

Healthcare Profile - Attestation

Healthcare Professions Profile | Attestation

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

- I am 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.

135. Submission Date:
03/27/2019

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.

COLORADO STATE BOARD OF MEDICAL EXAMINERS
APPLICATION FOR A PHYSICIAN TRAINING LICENSE **FEE $20.00**

READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS APPLICATION. ALL QUESTIONS MUST BE ANSWERED, AND ALL SUPPORTING DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION PER INSTRUCTIONS. THE ENCLOSED CHECKLIST IS PROVIDED FOR YOUR CONVENIENCE. PLEASE TYPE OR PRINT NEATLY. **WHEN SPACE PROVIDED IS INSUFFICIENT, ATTACH ADDITIONAL SHEETS IF NECESSARY.**

1 a. Name: Last First Middle Degree
FRASER, KRISTINA BARBARA M.D.

1b. Social Security Number
Redacted

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

3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE, Address provided is, by law, public information.)
☒ Home
☐ Business
364 SOUTH VINE STREET

City: DENVER State: CO Zip: 80209 Country: U.S.A

e-mail address: Redacted

4. Telephone Number: (Area Code) Day Evening
(303) 744. 3372 (Day + Evening)

5. Date of Birth: Mo/Day/Year
Redacted

6. Sex
Male (Female)

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

8. List name/address of the school where medical degree was received.

Name of School	City and State	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
University of Colorado	Denver, Colorado	8/95	6/99

9. List the name and address of the Colorado training program into which you have been accepted.
Name OBSTETRICS AND GYNECOLOGY UNIVERSITY OF COLORADO
Address 4200 EAST 9th AVENUE DENVER, CO 80262

SAME PROGRAM

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

Name of facility	Specialty	Period of attendance From (Mo/Yr)	To (Mo/Yr)
University of Colorado Health Sciences Center	OBSTETRICS AND GYNECOLOGY	6/99	6/2003

11. Are you now or have you ever been licensed to practice medicine in any state, territory, district or country? **Include temporary licenses and educational permits.** Request verification from each to be sent to the Colorado Board.
☐ Yes If yes, provide information below.
☒ No

State or country	License #	Dates of Practice in this jurisdiction Issue Date	Expiration Date

12. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic board of any complaint, investigation or inquiry, which is **currently pending?**
☐ Yes If yes, give details below.
☒ No

State	Date	Charge	Disposition

13. Has **any disciplinary action** ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity? (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question.
☐ Yes If yes, give details below.
☒ No

State	Date	Charge	Disposition

Official Use Only	License #: T4D	Date: 8/7/02
Revised 10/99	Fee $: 20	Date: 7-11-02

RECEIVED JUL 11 2002 BOARD OF MEDICAL EXAMINERS

T1A

14. Have you ever entered into any agreement with any state, territory, district, country, US government agency, and state medical/osteopathic board regarding your medical license?

☐ **Yes** If yes, give details below:

☒ **No**

Agency	Date	Reason

15. 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 US federal jurisdiction?

☐ **Yes** If yes, give details below:

☒ **No**

Agency	Date	Reason for denial

16. Have you ever been disciplined, dismissed, suspended, placed on probation, required to repeat any of your training or required to take a leave of absence while participating in a medical school, internship, residency or fellowship program?

☐ **Yes** If yes, give details below:

☒ **No**

Agency	Date	Reason

17. Have you taken a voluntary leave of absence from a medical school, internship, residency or fellowship program for either of the following reasons: a) in lieu of disciplinary action or potential disciplinary action; or b) during the past five years, for reasons related to a mental, physical or cognitive health condition that has affected or might affect your ability to practice medicine safely and competently (excluding pregnancy or parental leave)?

☐ **Yes** If yes, give details below:

☒ **No**

Agency	Date	Reason

18. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in any state country or U.S. federal jurisdiction? This does not include allowing your license to lapse solely due to non-payment of the renewal fee.

☐ **Yes** If yes, explain on a separate sheet, summarize below:

☒ **No**

Agency	Date	Reason

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

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

☒ **No**

Name of facility	Date	Reason for action

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

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

☒ **No**

Date	Court	Violation	Penalty or disposition

21. 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?

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

No

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

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

No

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

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

No

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

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

☒ **No**

Date	Name and address of Insurance Company	Reason for Action

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

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

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

I state under penalty of perjury, as defined in 18-8-503, C.R.S., that the information contained in this application is true and correct to the best of my knowledge. I further state that I have read all disclosures contained in the application packet including the one related to social security numbers.

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

I understand that this license will only be valid for the training program listed below, and should I enter another program, that I will need to re-apply.

I understand that this license will only be valid for the training program listed below, and should I wish to practice medicine in Colorado outside the training environment, I would need to apply for a license to practice medicine in the State of Colorado.

I further understand that the issuance of this training license is not a guarantee of issuance of a license to practice medicine in the State of Colorado.

Kristina Barbara Fraser — Signature

7/8/02 — Date

****

This section to be completed by Program Director, Clinical Director or by Training Supervisor

(NOTE: If separate statement has already been submitted to the Board, this section does not need to be completed. Please check with your training program to see if this information has been submitted to the Medical Board.)

Name of Training Program University of Colorado HSC

Location of Training Program Denver, CO

I certify that this applicant meets the criteria set forth in 12-36-122 (2) C.R.S., and that the training program indicated above, will accept responsibility for the applicant's medical training, while in the program.

X _____ — Signature of Program Director, Clinical Director or Supervising Physician

7/10/02 — Date

RETURN THIS APPLICATION AND FEE TO:

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

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
Kristina Barbara Fraser	Denver, CO 80209

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.0040987	Original	Physician	Active	10/15/2002	05/01/2019	04/30/2021

Board/Program Actions

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

Generated on: 7/9/2019 8:02:04 AM

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
Kristina Barbara Fraser	Denver, CO 80209

Credential Information

License Number	License Method	License Type	License Status	Original Issue Date	Effective Date	Expiration Date
TL.0000040	Original	Physician Training License	Expired	08/07/2002	08/07/2002	02/04/2003

Board/Program Actions

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

Generated on: 7/9/2019 8:02:22 AM