BOARD OF HEALING ARTS
235 SOUTH TOPEKA BOULEVARD - TOPEKA, KANSAS 66603-3068
TELEPHONE (785) 296-7413

walk-in keep July 1 date

~~RECEIVED JUL 01 2002~~
RECEIVED
JUN 30 2002

RENEWAL APPLICATION FOR MEDICINE AND SURGERY
JULY 1, 2002 TO JUNE 30, 2003

PLEASE REVIEW ALL ENCLOSURES BEFORE COMPLETING APPLICATION. TYPE OR PRINT USING BALLPOINT PEN. INCOMPLETE APPLICATIONS MAY RESULT IN CANCELLATION OF LICENSE. COMPLETION OF ALL INFORMATION ON THIS PAGE IS REQUIRED OF ALL LICENSEES REGARDLESS OF LICENSE STATUS. REFER TO INSTRUCTIONS ON THE BACK OF THIS FORM.

Kansas Medical License #: 04-21596 2. Office Phone #: (785)865-3500 3. SSN: (Confidential)

Name: NEUHAUS MD ANN

New Mailing Address: P. O. Box 605

(if different from address block) Street Address/P.O.Box Suite/Apt.

Lawrence KS 66044-0605

City State (and country if not USA) Zip Code + 4

Residence Address: (Confidential) Residence Phone Number: (Confidential)

MANHATTAN KS 66502 Fax Number:

Is your mailing address: __Your residence ✓Your practice, or __Other address?

Are you active in medicine and surgery in Kansas at least one hour per week? ✓ Yes ____ No

Are you currently enrolled in a residency program? ____ Yes ✓ No

If yes, where? _____

Institution City State Zip Code + 4

Are you retired? ____ Yes ✓ No

Please indicate your primary practice specialty using the appropriate code listed on back. Specialty Code 18

Please provide street, city, county, state & zip code for each of your practice locations.

1st Location 205 W. 8th Lawrence KS 66044 Phone Number 785-863-3500
Street Address Required (No P.O. Box)

2nd Location _____ Phone Number _____
Street Address Required (No P.O. Box)

YOU ARE REQUIRED TO ATTACH DOCUMENTATION AND A COMPLETE EXPLANATION IF YOUR ANSWER IS "YES" TO ANY OF THESE QUESTIONS.

) ____ Yes ✓ No Since May 1, 2001 has any judgment, award or settlement been paid in which you were named resulting from a professional liability claim?

) ____ Yes ✓ No Since May 1, 2001 have you been charged with or convicted of any felony or class A misdemeanor? This includes any plea to a felony or class A misdemeanor.

) ____ Yes ✓ No Since May 1, 2001 has any disciplinary action been taken or initiated against you by a state licensing agency or other state or federal agency, or have you surrendered or consented to limitation of license to practice in any state?

) ✓ Yes ____ No Since May 1, 2001 have you been denied a license to practice the healing arts or other health care profession?

) (Confidential)

) (Confidential)

PROOF OF MALPRACTICE INSURANCE COVERAGE REQUIRED FOR ACTIVE STATUS ONLY (see instructions on back).

THE INFORMATION PROVIDED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

✓ I DO PRACTICE IN KANSAS ____ I DO *NOT* PRACTICE IN KANSAS

SIGNATURE 5/3/02 DATE

2002 APPEARS IN THE ADDRESS BLOCK, PROOF OF CME HOURS IS DUE WITH THIS RENEWAL FORM.

04-21596 2002 ACT
ANN NEUHAUS MD
205 W 8TH ST
LAWRENCE KS 66044

✓	307336	4604 $531	05

KANSAS HEALTH CARE STABILIZATION FUND NOTICE OF BASIC COVERAGE FORM

The insurance company is required to forward this completed form and HCSF surcharge payment to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the date the insurer receives the basic coverage premium. A copy of this completed form must also be furnished to the health care provider.

For HCSF Use Only

SECTION I Individual Health Care Provider's Name, designation of M.D., D.O., D.C., D.P.M. or R.N.A.) or the name of the health care provider entity (professional association, partnership, hospital or other health care provider organization)

Health Care Provider's Name: NEUHAUS, ANN K.
LAST NAME (OR FULL NAME OF HEALTH CARE PROVIDER ENTITY) FIRST NAME MIDDLE INITIAL AND PROFESSIONAL DESIGNATION

Provider's Group Name: KEEP 7/1 date

Resident Address: **(Confidential)**

Phone Number: REC'D JUL 01 2002

City: MANHATTAN State: KS Zip: 66502 **(Confidenti**

RECEIVED JUN 30 2002

Business Address Of Health Care Provider: 205 W 8TH ST
** MAILING ADDRESS ** LAWRENCE KS 66044 2607

SECTION II For Health Care Providers WHO HAVE PREVIOUSLY SELECTED THEIR HEALTH CARE STABILIZATION FUND COVERAGE LIMITS. The previously selected Health Care Stabilization Fund coverage limits are:

[ ] $100,000/$300,000 [X] $300,000/$900,000 [ ] $800,000/$2,400,000

NOTE: A request to change Fund coverage limits form must be submitted to the Fund if an INCREASE or DECREASE to the previously selected Fund coverage limits is desired. The Fund Board of Governors MUST APPROVE all requests for INCREASED Fund coverage limits before such becomes effective. Blank copies of the REQUEST TO INCREASE OR DECREASE FUND COVERAGE LIMITS forms are available from your insurer or the Fund office.

SECTION III For **NEW** Health Care Providers Only. Check one of the following Health Care Stabilization Fund Coverage limits, enter the date signed, completing this section with your signature

[ ] $100,000/$300,000 [ ] $300,000/$900,000 [ ] $800,000/$2,400,000

DATE SIGNED

SIGNATURE OF HEALTH CARE PROVIDER

SECTION IV Insurance Policy Information And Health Care Stabilization Fund Surcharge Payment

HCSF Rate Classification No.	Provider's License, Registration or Certification Number	Basic Coverage Premium Amount	Number of Fund Compliance Years	HCSF Class Group No.	For Fund Classes 1 to 14: HCSF Surcharge Payment From Rate Tables	For Fund Classes 15 to 21: HCSF Surcharge %	For Fund Classes 15 to 21: HCSF Percentage Based Surcharge Payment
80420	0421596	4,537	5	2	956		

The Medical Protective Company
ENTER THE NAME OF INSURANCE COMPANY

Laura J. Miller
NAME OF INSURANCE AGENT OR COMPANY REPRESENTATIVE

260-486-0819
TELEPHONE NUMBER OF INSURANCE AGENT OR COMPANY REPRESENTATIVE

THE PUBLISHED SURCHARGE RATE FOR FUND CLASSES 1 TO 15 WAS MODIFIED BECAUSE THIS HEALTH CARE PROVIDER WAS ISSUED A BASIC PROFESSIONAL LIABILITY INSURANCE POLICY THAT WAS:

[ ] FOR LESS THAN ONE YEAR AND THE SURCHARGE PAYMENT WAS PRORATED. THE PRORATA FACTOR USED WAS:

[ ] SUBJECT TO A PART-TIME PRACTICE CREDIT RATING RULE APPROVED FOR USE BY THE BASIC PROFESSIONAL LIABILITY INSURER. THE PART-TIME FACTOR USED WAS:

[ ] THIS KANSAS RESIDENT HEALTH CARE PROVIDER IS LICENSED AND PRACTICES IN MISSOURI. YES [ ] NO [X]

Policy Number: 571435

Inception Date: 5/07/2002
OF THE BASIC PROFESSIONAL LIABILITY INSURANCE POLICY PERIOD

Coverage Effective Date: 5/07/2002
ENTER DATE THIS HEALTH CARE PROVIDER WAS ADDED TO AN EXISTING POLICY PERIOD

Expiration Date: 5/07/2003
OF THE BASIC PROFESSIONAL LIABILITY INSURANCE POLICY PERIOD

Type of Basic Coverage Professional Liability Policy
[ ] Occurrence [X] Claims Made

For HCSF Use Only

Notice to Health Care Provider: If you should *discontinue* your basic professional liability insurance policy because you are no longer rendering professional services as a Kansas resident health care provider, you should immediately contact the Kansas Health Care Stabilization Fund Board of *Governors and request information regarding the availability of the Health Care Stabilization Fund's continuing coverage for inactive health care providers.*