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State of Nevada - Board of Osteopathic Medicine
Application for Osteopathic Physician Licensure

JUL 30 2007

NV STATE BOARD OF OSTEOPATHIC MEDICINE

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

PAID 14807 650.00

Last Name	First Name	Middle Name	Suffix	Maiden Name
Thorndike	Lori	Lynn Holst		Holst

All other names used: Holst Lori Lynn

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Practice Address
☒ Public Access
☐ Mailing

2005 Franklin St. Suite 200
Street

Denver CO 80205
City State Zip Code

303 318-2000 303 318-2040 303 518-2938
Telephone Fax E-mail address Alternate Phone

Home Address
☐ Public Access
☒ Mailing

[redacted]
Street

Denver CO 80205
City State Zip Code

303 [redacted]
Telephone Fax E-mail address Alternate Phone

Medical Specialty: Family Medicine

Are you Board Certified in the above specialty? ☐ **Yes** ☒ **No**
If yes, please complete the following:

Specialty Board	Certification Number	Date of Certification	Date of Re-Certification

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

[redacted] Pittsburgh, PA USA

Date of Birth (mm/dd/yyyy) | Birth City | Birth State | Birth Country

F | [redacted] | Are you a U.S. Citizen? ☒ Yes ☐ No

Gender | Social Security Number

5'6 | 140 | blonde | blue

Height | Weight | Color of Hair | Color of Eyes

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law (NRS 633.326).

4. List name and address for any and all colleges or universities attended other than schools where professional medical education was received.

4. Colleges or Universities (attach additional pages if necessary)

1. Colorado College 14 East Cache La Poudre St.

School Name | Address

Colorado Springs, CO 80903 USA 6/94 – 6/98 6/98 BA

City | State | Zip Code | Country | Attendance Dates From – To | Graduation Date | Degree

2. _____

School Name | Address

City | State | Zip Code | Country | Attendance Dates From – To | Graduation Date | Degree

5. Medical School: List **all** medical schools you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary.

5. Medical School (attach additional pages if necessary)

1. University of New England COM 11 Hills Beach Rd.

School Name | Address

Biddeford, ME 04005 USA 8/00 – 6/04 6/5/04 D.O.

City | State | Zip Code | Country | Attendance Dates From – To | Graduation Date | Degree

2. _____

School Name | Address

City | State | Zip Code | Country | Attendance Dates From – To | Graduation Date | Degree

6. Child Support Information (per NRS 633.326)

Please mark the appropriate response:

X I am NOT subject to a court order for the support of a child.

_____ I AM subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the District Attorney or other controlling public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ I AM subject to a court order for the support of one or more children and am not in compliance with the order or a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

[redacted]
Signature of Applicant

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)	Number of attempts
☐ State Board Exam ____ (State)	_____	☐ P ☐ F	____
☒ NBOME Part I	2002	☑ P ☐ F	1
☒ NBOME Part II	8/2003	☒ P ☐ F	1
☒ NBOME Part III	9/2005	☒ P ☐ F	1
☐ COMVEX	_____	☐ P ☐ F	____
☐ COMLEX	_____	☐ P ☐ F	____
☐ SPEX	_____	☐ P ☐ F	____
☐ FLEX Pre-1985	_____	☐ P ☐ F	____
☐ FLEX Component 1	_____	☐ P ☐ F	____
☐ FLEX Component 2	_____	☐ P ☐ F	____
☐ NBME Part I	_____	☐ P ☐ F	____
☐ NBME Part II	_____	☐ P ☐ F	____
☐ NBME Part III	_____	☐ P ☐ F	____
☐ USMLE Step I	_____	☐ P ☐ F	____
☐ USMLE Step II	_____	☐ P ☐ F	____
☐ USMLE Step III	_____	☐ P ☐ F	____

8. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

8. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1. Exempla St. Joseph's Hospital
Hospital Name

2005 Franklin St. Suite 200 Denver, CO 80205 USA
Hospital Address — City — State — Zip Code — Country

PGY: 1 (e.g., 1, 2, 3, etc.) ☒ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other_____

Department/Specialty: Family Medicine

From: 6 / 04 (Month / Year) To: 6 / 05 (Month / Year) Successfully Completed? ☒ Yes ☐ No ☐ In Progress

2. Sameas #1
Hospital Name

Hospital Address — City — State — Zip Code — Country

PGY: 2 (e.g., 1, 2, 3, etc.) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other_____

Department/Specialty: Family Medicine

From: 6 / 05 (Month / Year) To: 6 / 06 (Month / Year) Successfully Completed? ☒ Yes ☐ No ☐ In Progress

3. Same as #2
Hospital Name

Hospital Address — City — State — Zip Code — Country

PGY: 3 (e.g., 1, 2, 3, etc.) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other_____

Department/Specialty: Family Medicine

From: 6 / 06 (Month / Year) To: 6 / 07 (Month / Year) Successfully Completed? ☐ Yes ☐ No ☒ In Progress

4.
Hospital Name

Hospital Address — City — State — Zip Code — Country

PGY: ___ (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other_____

Department/Specialty: _____

From: ___ / ___ (Month / Year) To: ___ / ___ (Month / Year) Successfully Completed? ☐ Yes ☐ No ☐ In Progress

9. State or Professional Licensure: You must complete the attached "Licensure Verification" form and forward it to **all** states in which you have held **any** healthcare license or certification. The verifying entity must forward all documentation directly to this board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure –DO only – all others complete the section below; attach additional pages if necessary

1. State CO Type Full (Special, Training, or Full License) License Number 44567 Status active Issue Date 6/1/07
2. State_____ Type_____ (Special, Training, or Full License) License Number_____ Status_____ Issue Date_____
3. State_____ Type_____ (Special, Training, or Full License) License Number_____ Status_____ Issue Date_____
4. State_____ Type_____ (Special, Training, or Full License) License Number_____ Status_____ Issue Date_____
5. State_____ Type_____ (Special, Training, or Full License) License Number_____ Status_____ Issue Date_____
6. State_____ Type_____ (Special, Training, or Full License) License Number_____ Status_____ Issue Date_____
7. State_____ Type_____ (Special, Training, or Full License) License Number_____ Status_____ Issue Date_____
8. State_____ Type_____ (Special, Training, or Full License) License Number_____ Status_____ Issue Date_____
9. State_____ Type_____ (Special, Training, or Full License) License Number_____ Status_____ Issue Date_____
10. State_____ Type_____ (Special, Training, or Full License) License Number_____ Status_____ Issue Date_____

All Other Healthcare Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State_____ Type_____ License Number_____ Status_____ Issue Date_____
2. State_____ Type_____ License Number_____ Status_____ Issue Date_____
3. State_____ Type_____ License Number_____ Status_____ Issue Date_____
4. State_____ Type_____ License Number_____ Status_____ Issue Date_____
5. State_____ Type_____ License Number_____ Status_____ Issue Date_____

Applicant Name: Lori Thorndike Date: 6/24/07

10. Chronology of Activities: Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from medical school to the present date, leaving no time period unaccounted for in your resume. Use an additional page to account for non-professional activities and any other gaps in time between professional experiences, including military duty.

10. Chronology of Activities (copy and attach additional pages if necessary)

I have not had any other employment beyond the residency program which I am completing this month.

Dates: From/To	Practice/Employment
1. From: To:	Practice/Employment Name Practice/Employment Address City State Zip Code Country Position & Department: _____ % Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
2. From: To:	Practice/Employment Name Practice/Employment Address City State Zip Code Country Position & Department: _____ % Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
3. From: To:	Practice/Employment Name Practice/Employment Address City State Zip Code Country Position & Department: _____ % Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
4. From: To:	Practice/Employment Name Practice/Employment Address City State Zip Code Country Position & Department: _____ % Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
5. From: To:	Practice/Employment Name Practice/Employment Address City State Zip Code Country Position & Department: _____ % Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____

11. Questions: Please answer yes or no to the following questions. All, 'yes', answers must be explained on a separate sheet of 81/2 x 11 piece of paper. Each numbered question corresponds to a numbered, 'yes', or, 'no', check box on the right side of this page.

1. Have any disciplinary or administrative actions ever been taken against any healing art license which you now hold or have held? Include any disciplinary and administrative actions by the U.S. Military, U.S. Public Health Service or other U.S. federal government entity. 1. ☐Yes ☒No

2. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country, or U.S. territory? 2. ☐Yes ☒No

3. Have you ever had a medical license revoked, suspended, or limited in any state, or U.S. territory? 3. ☐Yes ☒No

4. Have you ever voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? 4. ☐Yes ☒No

5. Have you ever failed a state licensure examination, any part of FLEX, COMLEX, USMLE, or NBOME even if subsequently passed? 5. ☐Yes ☒No

6. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or non-renewed, or have you ever resigned from a medical staff in lieu of disciplinary or administrative action? (This does not include suspensions or restrictions for failure to complete medical records). 6. ☐Yes ☒No

7. Have you ever been investigated for, charged with, or convicted of unprofessional conduct, professional incompetence, gross or repeated malpractice, or any other violation or statute, rule or regulation governing the practice of medicine by any medical licensing board or other agency (including Federal), hospital or medical society? 7 ☐Yes ☒No

8. Have you ever been denied membership or expelled from a medical society or other professional medical organization including the AOA, AMA, any member specialty board of the AOA or ABMS? 8. ☐Yes ☒No

9. Are you currently in treatment for a mental illness, drug addiction, or acute substance, drug or alcohol abuse? 9. ☐Yes ☒No

10. Do you regularly take any prescription drug for therapeutic purposes? 10. ☐Yes ☒No

11. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way? 11. ☐Yes ☒No

12. Are you now or were you in the past, addicted to controlled substances, including, but not limited to narcotics or alcohol? 12. ☐Yes ☒No

13. Have you ever been investigated for, charged with or convicted of, or pled nolo contend ere to a violation of any federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances, or to drug addiction? 13. ☐Yes ☒No

14. Have you ever been arrested, investigated for, charged with or convicted of, or pled nolo contend ere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? (Except violations of traffic laws resulting in fines of $75.00 or less). 14. ☐Yes ☒No

15. If granted a license, do you intend to practice in Nevada? 15. ☒Yes ☐No

If yes, LOCATION yet to be determined

When: Fall or Winter 2007

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

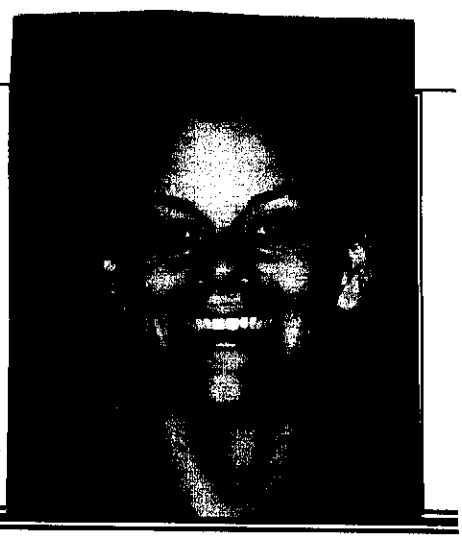
I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

[redacted]
Applicant's Signature (must be signed in the presence of a notary)

Thorndike
Applicant's **Printed** Last Name

Lori Lynn Holst
Applicant's **Printed** First Name, Middle Initial, and Suffix (e.g., Jr.)

Date of Signature



NOTARY

Dated 6/26/07 Signed Laurel Allen

State of Colorado County of Denver

SUBSCRIBED AND SWORN TO before me this 26th day of June, 2007

My commission expires: 8-15-09 (NOTARY PUBLIC SIGNATURE & SEAL)