425 00 CK # 341 8/12 AP

COLORADO STATE BOARD OF MEDICAL EXAMINERS

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

READ ALL INSTRUCTIONS PRIOR TO COMPLETING TH
MUST BE ANSWERED, AND ALL SUPPORTING DOCUM
PER INSTRUCTIONS. THE ENCLOSED CHECKLIST IS
PRINT NEATLY. WHEN SPACE PROVIDED IS INSUFFI
MAY REPRODUCE THESE BLANK FORMS AS NEEDED
ORIGINAL INK OR TYPE. **MAKE SUFFICIENT COPIES**

BOARD CERTIFIED ON R IN

1 a. Name: Last	First	Middle	Degree	[redacted]
GINDE	SAVITA	Y	MD	

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

What is your speciality(s): FAMILY MEDICINE, FAMILY PLANNING

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

☑ Home ☐ Business 1111 LAC DE VILLE BLVD #101

City	State	Zip	Country
ROCHESTER	NY	14618	USA

e-mail address: [redacted]

4. Telephone Number: (Area Code) (Day) Evening: (585) 473-9016

5. Date of Birth: Mo/Day/Year [redacted] Place of Birth: TOLEDO, OH

6. Sex: Male (Female)

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

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)
AMERICAN UNIVERSITY OF THE CARIBBEAN	MEDICAL, 901 PONCE DE LEON BLVD, STE 401 CORAL GABLES FL 33134-3036	09/93	06/97

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
ECFMG (BASIC)	OHIO	9/95	[redacted]
ECFMG (CLINICAL & ENGLISH)	OHIO (both)	3/97 (both)	
USMLE STEP 1, STEP 2	OHIO (both)	Step1: 9/95 Step2: 3/97	
USMLE STEP 3	OHIO	9/00	

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)
CONCORD HOSPITAL	FAMILY MEDICINE	07/99	06/01
MT SINAI MEDICAL CENTER	INTERNAL MEDICINE (TRANSITIONAL)	07/98	06/99

11. Are you Board Certified by either the American Board of Medical Specialties or the American Osteopathic Association?
☑ Yes, if yes, list certification information. DIPLOMATE OF AMERICAN BOARD OF FAMILY PRACTICE SINCE 07/2002
☐ No

L1A

Official Use			
Revised 10/99	Fee $		Date:

425.00 10-09-03

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AUG 12 2003

DIVISION OF REGISTRATIONS

12. 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.

[redacted]

13. 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?**

[redacted]

14. 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.

[redacted]

15. 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?

[redacted]

16. 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?

[redacted]

17. 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.

[redacted]

L1B

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, SAVITA YESHAWANT GINDE 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 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.

Signature

July 24, 2003
Date

RETURN THIS APPLICATION TO:

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

L1D

QUESTIONS FOR INTERNATIONAL MEDICAL SCHOOL GRADUATES

(PLEASE COMPLETE AND RETURN WITH MAIN APPLICATION)

Name SAVITA YESHAWANT GINDE

A. YES OR NO QUESTIONS

Instructions for answering yes or no questions:

1. Answer each of the questions below either yes or no. In the case where you do not know the answer, check "no" and provide an explanation on a separate sheet of paper. The mere statement that you do not know the answer is not adequate. You must make reasonable inquiry of your medical school for the information. If you have made reasonable inquiry and still have not been able to obtain the information requested, you must set out what reasonable effort you have conducted, including the names of all persons contacted in making your inquiry.

2. If the answer to any question below is "no" you must provide an explanation on a separate sheet of paper. You must explain to the satisfaction of the Colorado State Board of Medical Examiners why you believe your school provided a high quality medical education to all of its students (not just yourself) despite this apparent weakness.

Governance

1. At the time of your attendance, was your medical school a component of a university that had other graduate and other professional degree programs?
   ☒ Yes ☐ No

2. At the time of your attendance, was your medical school part of a not-for-profit university or chartered as a not-for-profit institution by the government of the jurisdiction in which it operated?
   ☒ Yes ☐ No

Administration

3. At the time of your attendance, did your medical school have a chief official or "Dean" qualified by education and experience to provide leadership in medical education?
   ☒ Yes ☐ No

Educational Program

4. At the time of your attendance, did your medical school provide at least 130 weeks of instruction?
   ☒ Yes ☐ No

5. At the time of your attendance, did the curriculum of your medical school include all of the following disciplines: anatomy, biochemistry, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine?
   ☒ Yes ☐ No

6. At the time of your attendance, did your medical school provide for laboratory or other practical exercises in the disciplines set out in question 5 above?
☒ Yes ☐ No

7. At the time of your attendance, did your medical school provide for clinical education programs involving actual patients in all of the following disciplines; family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery?
☒ Yes ☐ No

8. At the time of your attendance, were the clinical education programs mentioned in question 7 above conducted in teaching hospitals?
☒ Yes ☐ No

9. At the time of your attendance, did your medical school publicize to all faculty members and students its standards and procedures for the evaluation, advancement, and graduation of its students and for disciplinary action?
☒ Yes ☐ No

Medical Students

10. At the time of your attendance, did your medical school require three or more years of undergraduate education for entrance into the medical school?
☒ Yes ☐ No

11. At the time of your attendance, were the criteria and procedures for the selection of students published and available to potential applicants and their undergraduate advisors?
☒ Yes ☐ No

12. At the time of your attendance, did your medical school provide financial aid to students?
☒ Yes ☐ No

13. At the time of your attendance, did your medical school provide a student health service available to all medical school students?
☒ Yes ☐ No

Resources for the Educational Program

14. At the time of your attendance, did your medical school only enroll the number of students that the school's total resources could accommodate?
☒ Yes ☐ No

15. At the time of your attendance, did your medical school have buildings and equipment that were quantitatively and qualitatively adequate to provide an environment conducive to high productivity of faculty and students?
☒ Yes ☐ No

16. At the time of your attendance, did the persons appointed to the faculty have demonstrated achievements within their disciplines commensurate with their faculty rank?
☒ Yes ☐ No

17. At the time of your attendance, did your medical school have a library, sufficient in size and breadth, to support the educational programs offered by the institution?
☒ Yes ☐ No

18. At the time of your attendance, did the library at your medical school have a library staff to supervise the library and to provide instruction in its use?
☒ Yes ☐ No

B. OTHER QUESTIONS AND REQUESTS FOR INFORMATION

1. What year was your medical school founded? 1978

2. **You must, in typewritten response, explain in your own words why you feel your medical school provided a high quality medical education. In your answer, please discuss the following: How did your medical school prepare its graduates to enter and complete graduate medical education to qualify for licensure, to provide competent medical care and to have the educational background for continued learning.**

I state under penalty of perjury in the second degree, as defined in 18-8-503, Colorado Revised Statutes, that the information contained herein 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.

[signature] _____
Signature

JULY 24, 2003
Date

L9/c

UNIVERSITY OF
ROCHESTER
MEDICAL CENTER

DEPARTMENT OF FAMILY MEDICINE
AT HIGHLAND HOSPITAL

Applicant: Savita Y. Ginde MD

Applicant response to QB(2) on form L9/c:

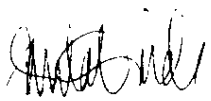
Why the American University of the Caribbean provided a quality medical education:

The American University of the Caribbean (AUC) was established in 1978 and has since been continually evolving and improving its medical school curriculum in order to provide a quality medical education similar to that provided by U.S. medical schools. AUC is a medical school that is listed in the World Directory of Medical Schools published by the World Health Organization (WHO) in Geneva, Switzerland.

Both the medical curriculum and its faculty are fully accredited by their appropriate authorities. Specifically, AUC's medical curriculum is accredited by the U.S. Department of Education and consists of basic sciences as well as clinical knowledge and skill development. The faculty consists of accredited and qualified members who teach with great enthusiasm and are dedicated to the development of qualified, compassionate, and competent physicians.

All of my clinical clerkships were completed at U.S. teaching hospitals alongside U.S. medical students. The performance evaluation of my clinical skills and knowledge throughout this education was held to the same standard as that of the U.S. medical students completing the rotations with me.

It is with this education that I have passed all U.S. Board Exams and competently completed Family Medicine Residency and Fellowship Programs. These solid components of AUC have provided me with a firm foundation of medical education and have thus contributed to my overall success as a qualified clinician.



Reproductive Health Program
Highland Hospital
1000 South Avenue, Box 101
Rochester, New York 14620
(585) 341-6292 Fax: (585) 341-6293

AMERICAN BOARD OF FAMILY PRACTICE, INC.

Founded 1969

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AUG 13 2003
DIVISION OF REGISTRATIONS

August 07, 2003

To Whom It May Concern:

This letter will verify that SAVITA YESHAWANT GINDE, MD, is certified by the American Board of Family Practice (ABFP) for the period 2002-2009. This certification is time limited for a period of seven years and must be renewed through successful completion of the ABFP recertification process and examination.

Sincerely,

Debbie Wilson
Verifications

2228 Young Drive
Lexington, KY
40505-4294

Tel: (859) 269-5626
(888) 995-5700
Fax: (859) 335-7501
(859) 335-7509
Web: www.abfp.org

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

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
Kresge Eye Institute, 1. Wayne State University	Hutzel Hospital, 4717 St. Antoine Detroit MI 48201	Dong H. Shin MD PhD Prof. of Ophthalmology	06/1997 to 01/1998	Ophthalmology Research Extern
American Foundation 2. for the Blind	11 Penn Plaza, Suite 300 New York NY 10001	Corinne Kirchner PhD Director of Policy Research & Program Evaluation	02/1998 to 06/1998	Low Vision Rehabilitation Policy Research Intern
Mt. Sinai Medical 3. Center, CWRU	One Mount Sinai Drive Cleveland OH 44106	Roy Ferguson MD, Program Director, Dept. of Internal Medicine	07/1998 to 06/1999	PGY-1, Transitional Program, Intern
NH-Dartmouth Program 4. Concord Hospital	250 Pleasant Street Concord NH 03301	Daniel F. Eubank MD Program Director, Dept of Family Medicine	07/1999 to 06/2001	PGY-2 & PGY-3 Residency training
Highland Hospital, 5. Reproductive Health Program	University of Rochester, 1000 South Avenue Rochester NY 14620	Eric Schaff MD Program Director, Dept of Family Medicine	07/2001 to 09/2003	PGY-4 & PGY-5 Fellowship Training
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.

SIGNATURE | GINDE (PRINT LAST NAME) | AUGUST 7, 2003 (DATE)

L6

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
PO Box 619850
DALLAS, TX 75261-9850

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

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

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

JUL 30 2003

DALE L. AUSTIN
SENIOR 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 SAVITA YESHAWANT GINDE

ADDRESS 3800 JOYCE ANN DRIVE

CITY, STATE AND ZIP CODE YOUNGSTOWN OH 44511

DATE OF BIRTH [redacted]

SOCIAL SECURITY NUMBER [redacted]

MEDICAL SCHOOL AMERICAN UNIVERSITY OF THE CARIBBEAN

DATE OF GRADUATION JUNE 7 1997

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

Signature

July 25, 2003
Date

L7

RECEIVED JUN 0 1 1999

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: School of Medicine, American University of the Caribbean

Complete Address: Post Office Box 400
Street Address
Plymouth Montserrat
Street Address
British West Indies
City State Zip Code(Postal Code)

If name of institution was different when this individual attended, please note this name below:

Enrollment and Participation: Our records indicate that Gindey, Savita Yeshawant
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 144 weeks of continuous on-campus education on the following dates (mm/dd/yy):

From	To
08 / 30 / 93	05 / 01 / 94
05 / 02 / 94	01 / 01 / 95
01 / 02 / 95	04 / 30 / 95
08 / 28 / 95	04 / 26 / 96
04 / 27 / 96	01 / 05 / 97
01 06 97	06 07 97

This individual (check one):

____ was awarded the degree of Doctor of Medicine on 06 / 07 / 97 (mm/dd/yy)

____ was NOT awarded a degree (please attach an explanation)

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response. **"Yes" responses to any of these questions requires a written explanation.**

Questions	Response
Did this individual ever take a leave of absence or break from their medical education?	(Yes) No
Was this individual ever placed on probation?	Yes (No)
Was this individual ever disciplined or under investigation?	Yes (No)
Were any negative reports regarding this individual ever filed by instructors?	Yes (No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes (No)

Premedical Education: Does your school have a premedical education requirement? (Yes) No

If yes, include where your records indicate the individual completed his/her premedical education and the basic science courses taken (attach additional pages if necessary):

Premedical Institution(s): University of Pennsylvania
University of Cincinnati

Check Courses Taken: X Physics ✓ Biology/Zoology
✓ Organic Chemistry ✓ Inorganic Chemistry

Certification: By my signature, I, Yife Tien (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized).

SEAL VERIFIED

Signature: Yife Tien

Title: Director

Date of Signature: 5/26/99

Telephone: (305) 446 0600