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APR 18 2007

DIVISION OF REGISTRATIONS

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: Knight | First: Natasha | Middle: Moselle | Degree: MD

1b. Social Security Number: [redacted]

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

What is your speciality(s): Obstetrics and Gynecology

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

☒ Home ☐ Business: 1370 Hibiscus Ave

City: Winter Park | State: FL | Zip: 32789 | Country: US

e-mail address: TMKNIGHT2@YAHOO.COM

4. Telephone Number: (Area Code) Day: 407-310-3853 | Evening: same

5. Date of Birth: Mo/Day/Year: [redacted] | Place of Birth: Bitburg, Germany (USAFB)

6. Sex: Male / (Female)

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

8.a. 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)	Period of Attendance To (Mo/Yr)
University of Florida	PO Box 100216 Gainesville, FL 32610-0216	8/1992	5/1996

8 b. If this is an international medical school, please provide the country where the school is physically located: N/A

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	[redacted]
USMLE Step 1	Florida	1995	
USMLE Step 2	Florida	1996	
USMLE Step 3	Florida	5/97	

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)	Period of attendance To (Mo/Yr)
University of Florida	Internship - OB/GYN	7/1996	7/1997
University of Florida	Residency - OB/GYN	7/1997	6/2000

11. Are you Board Certified by either the American Board of Medical Specialties or the American Osteopathic Association?
☒ Yes. If Yes, list certification information. By the American Board of Obstetrics and Gynecology on 1/1993 **L1A**
☐ No

Official Use Only	License # 45757	Date 4/15/07
Revised 10/99	Fee $	Date:

4/15/07

PAID 4/25/07 169099 CK

CK# 1079 4/23/07 SP

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]

State or Country	License #	Dates of Practice in this jurisdiction	
[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] give details below and request official complaint and/or investigative report be sent directly to the Board from the licensing [redacted] as personally submit a narrative regarding the complaint.

State	Date	Charge	Disposition

14. Has **any** healing arts license which you now hold or have ever held been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any healthcare facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question.

[redacted]

State	Date	Charge	Disposition

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] Yes, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or [redacted]ands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason

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] If Yes, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders, [redacted]ements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason for denial

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] Yes, summarize below AND request all official disciplinary documents including initial complaint, stipulations, orders, [redacted]nents or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason

18. Have either your medical staff membership or clinical privileges at any hospital or healthcare facility or your DEA registration been voluntarily or involuntarily reduced, limited, placed on probation, not renewed or relinquished or have either of the following been denied, revoked or suspended? You must answer "yes" if any of these actions are currently pending. You must answer "yes" if you have withdrawn or failed to proceed with an application for these items.

[redacted] If **Yes**, summarize below AND request hospital or DEA to submit a report directly to the Board regarding the action. Also submit narrative regarding the action taken.

Name of facility	Date	Reason for action

19. 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.

[redacted] If **Yes**, summarize below AND submit your narrative regarding the incident as well as court and police records and information regarding final disposition of the case.

	Court	Violation	Penalty or disposition

20. 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?
- Had any change in a condition described above that might affect your ability to practice medicine safely and competently?
- Illegally or excessively used any controlled substance, habit-forming drug, prescription medication or alcohol?
- Been diagnosed with or treated for bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder a neurological illness or sleep disorder that disturbs your cognition, behavior or motor function?

You may answer NO if the behavior or condition is already known to the Colorado Physician Health Program ("CPHP"). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

[redacted] If **Yes**, submit explanation to the Board regarding the diagnosis or disorder(s). Be specific as to date of occurrences, the type of disorder involved, and what if anything has been done to treat the disorder. Please submit copies of any discharge summaries, evaluations, reports, DUI or DWAI records, police reports, and court records directly to the Board.

21. 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?

[redacted] **Yes**, summarize below AND submit to the Board a completed malpractice claims form and a clinical narrative regarding your involvement in the case.

	Name and address of Insurance Company	Reason for Action

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

[redacted] If **Yes**, submit to the Board an explanation regarding the cancellation or increase in premiums of the insurance and verification directly from the insurance company to the Board.

23. 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: "d" **L1C**

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, Natasha M. Knight MD 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.

I understand that if my application does not have any issues which require Board review my application will be administratively approved as soon as it becomes complete unless I indicate otherwise below.

☒ Process my application for review now.

☐ Process my application for review on or after (list month and year):_____

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 _____ Date 4/10/07

RETURN THIS APPLICATION TO:

COLORADO BOARD OF MEDICAL EXAMINERS
1560 BROADWAY, SUITE 1350
DENVER CO 80202-5140

[redacted]

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS **Department of Regulatory Agencies**
1560 Broadway, Suite 1350
Denver, Colorado 80202-5146
Phone (303) 894-7800
Fax (303) 894-7693
V/TDD (303) 894-7880
www.dora.state.co.us/medical

Division of Registrations

REPORT OF PRACTICE HISTORY

	Facility Name	Address and Zip	Reference (name and title)	Dates of Practice From-To	Nature of Practice
ok	1. Premier OB/Gyn	531 N. Maitland Ave Maitland, FL 32751	Dr. John VanWert associate	7/2003–present	Private Practice OB/Gyn
ok	2. Loch Haven OB/Gyn	235 E. Princeton St. #200 Orlando, FL 32804	Dr. Ashely Hill associate	7/2000 – 6/2003	Hospital based Private Practice
ok	3. Florida Hospital Winter Park	200 N. Lakemont Ave Winter Park FL 32792	Dr. Steve Dukes Chief of Staff	7/2000 — present	OB/Gyn
ok	4. Arnold Palmer Hospital	83 West Miller St. Orlando, FL 32806	Dr. Oliver Bayadth MD Dept. Chief	7/2003 – present	OB/Gyn
B	5. University of Floride Jacksonville	1053-1 W. 8th St Jacksonville, FL 32209	Dr. Guy Bonnabi Chairman	7/1994 - 5/2000	Residency
	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 | Knight (PRINT LAST NAME) | 4/11/07 (DATE)

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Department of Regulatory Agencies
Division of Registrations

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 Natasha Moselle Knight
FULL NAME OF APPLICANT

enrolled in The University of Florida College of Medicine
FULL NAME OF MEDICAL SCHOOL

at Gainesville on the 25 day of May 19 96
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 19th day of August, 1992 and was granted the degree Bachelor/(Doctor of Medicine) or Doctor of Osteopathy on the 25th day of May, 1996.

Signed and the college seal affixed

This 16th day of April, 2007

By Amelia E. Jaworski AMELIA E. JAWORSKI SENIOR REGISTRAR OFFICER FOR MEDICINE

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

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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 Natasha Moselle Knight
FULL NAME OF APPLICANT

a graduate of University of Florida College of Medicine
FULL NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in University of Florida College of Medicine at Jacksonville - 653-1 W. 8th St
NAME AND ADDRESS OF FACILITY

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

on July 1, 96 and satisfactorily completed such training on June 30, 2000.

This training 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 See attached. LENGTH OF ROTATION

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

YES ✓ NO ____

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 Guy I. Benrubi MD.

ADDRESS OBGYN@UFCOMJ-653-1 W 8th St Jax FL 32209

PHONE NUMBER 904-244-3112 DATE 4-12-07

SIGNATURE _____

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