STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
Department of Regulatory Agencies
Division of Registrations

JUL 27 1998

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690 V/TDD (303) 894-2900 ext. 833
FAX: (303) 894-7692

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE

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.**

ALLEN JODELL K M.D.

OFFICE USE ONLY

1a. Name: Last First Middle Degree

ALLEN JODELL K M.D.

1b. Social Security Number [redacted]

PERSONAL DATA

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

N/A - None

L7 ☒

3. Mailing Address: Number and Street/Rural Route, Apartment Number This is my home ☒ business ☐

10766 E. MAPLEWOOD DRIVE

NPDB ☐

City State Zip Country

ENGLEWOOD CO 80111 USA

4. Telephone Number: (Area Code) Day Evening

(303) 779-8851 SAME

5. Date of Birth: Mo/Day/Year [redacted] Place of Birth: St. Paul, MN USA

Submit a certified or notarized copy of your birth certificate or passport.

BC ☒

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 and address of college or university where pre-medical degree was received.

PRE-MED EDUC

Name of School	Address and zip	Period of attendance From (Mo/Yr)	To (Mo/Yr)
Gustavus Adolphus College	800 W. College Ave / St Peter, MN 56082	01/77	05/80
U of CO at Denver	P.O. Box 173364 / Denver, CO 80217-3364	01/84	05/88

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

MEDICAL EDUC L2 ☒

Name of School	Address and zip	Period of attendance From (Mo/Yr)	To (Mo/Yr)
U of CO Health Sciences Cntr.	4200 E. 9th Ave / Denver, CO 80262	08/88	05/95

BOARD OF MEDICAL EXAMINERS

AUG 27 1998

STATE OF COLORADO

Official use only

License # 31420 Date 10/15/98

Fee$ 315 Date 8/31/98

Org. 8/86
Revised 9/92
Revised 11/95
Revised 4/96
Revised 12/96
Revised 1/97

L1A

OFFICE USE ONLY

WRITTEN EXAM

10. Have you ever taken any of the following written examinations: ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam?
If yes, request certification of scores from examining agency be sent directly to this office. If you did not take a national exam (i.e. FLEX, NBME, NBOME, USMLE, LMCC) then request verification and scores from the state examinating agency. (See " Summary of Requirements") Provide information below:

Exam	Location	Date	Result
USMLE I	Denver, CO	Sept 1994	[redacted]
USMLE II	Denver, CO	March 1994	
USMLE III	St. Paul, MN	May 1998	

POSTGRAD TRAINING

11. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian facilities?
☒ Yes ☐ No
If yes, provide information below. Request an original L3 Form (Certificate of Completion of ACGME/AOA Postgraduate Training) from each facility attended for internship and residency training.

Name of facility	Address and zip	Specialty	Period of attendance: From (Mo/Yr)	To (Mo/Yr)
Regions Hospital	640 Jackson St. St. Paul, MN 55101	OB/GYN	6/97	6/98
Sinai Samaritan Medical Center (VOA 8/25/98)	945 N. 12th St. 3A P.O. Box 342 Milwaukee, WI 53201	OB/GYN / INT MED	6/95	12/95

LICENSE DATA

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

State or country	License number	Date of issue	Dates of practice in this jurisdiction: From (Mo/Yr)	To (Mo/Yr)

13. Are you now or have you ever practiced medicine in any state, territory, district, or country, U.S. Military, U.S. Public Health, or any U.S. government agency? ☐ Yes ☒ No (See Form L6 - Report of Practice History)

L6 ☒

14. 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 ☒ No
If yes, give details below:

State	Date	Charge	Disposition	REQ	REC
				☐	☐
				☐	☐
				☐	☐

15. 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.) ☐ Yes ☒ No
If yes, give details below:

State or government agency	Date	Charge	Disposition	REQ	REC
				☐	☐
				☐	☐

Office use only

	LICENSE DATA (continued)
24. Within the last five years, has any final judgement, settlement or arbitration award for medical malpractice been paid on your behalf or has any claim been filed which is still pending? [redacted] If yes, list below and complete the enclosed Claims [redacted]	REQ REC ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
25. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been cancelled or rated at a higher premium due to past claims experience? If yes, explain on a separate sheet and provide verification of same from insurance company or state licensing board. [redacted]	REQ REC ☐ ☐
26 You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado Law, or claim one of the seven 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 an exemption applicable at the time you submit your application.	INS ☑

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, JODELL K. ALLEN, 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.

PLEASE BE ADVISED 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 Colorado Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

Signature

7/20/98
Date

L1D

STATE OF COLORADO

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BOARD OF MEDICAL EXAMINERS
SEP 1 1998
STATE OF COLORADO

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Jodell Kay Allen
FULL NAME OF APPLICANT

of JCA 8/20/98 10761 E. Mapiewood Drive, Englewood, CO 80111
ADDRESS WHEN ENROLLED

enrolled in University of Colorado Health Sciences Center
FULL NAME OF MEDICAL SCHOOL

4200 E. Ninth Ave., Denver, CO 80262 on the ~~28~~ 29 day of August, 1988
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 29 day of August, 19 88 and was granted the degree Bachelor/Doctor of Medicine or Doctor Osteopathy on the 27 day of May, 19 95

Signed and the college seal affixed
this 28 day of August, 19 98.
By Phyllis V. Cunningham Reg. Asst #
303-315-4354

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:

IF NO SCHOOL SEAL, PLEASE INDICATE ABOVE NEXT TO SIGNATURE OF PRESIDENT/SECRETARY/DEAN.

L2

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FEDERATION OF STATE MEDICAL BOARDS
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

NAME Jodell Kay Allen

ADDRESS 10766 E. Maplewood Drive

CITY, STATE AND ZIP CODE Englewood, CO 80111

DATE OF BIRTH [redacted]

SOCIAL SECURITY NUMBER [redacted]

MEDICAL SCHOOL University of Colorado Health Sciences Center

DATE OF GRADUATION May 1995

I hereby authorize and request that the Federation of State Medical Boards of the United States Inc. provides a disciplinary history to the following:

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

Signature

8-20-98
Date

To complete your application we must have a report form the Federation's National Data Bank of disciplinary actions taken by by state licensing boards and/or other credentialing entities regarding the above named physician. If we have no unfavorable information note: an unfavorable report does not automatically disqualify you from licensure in Colorado.

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

AUG 26 1998

James R. Winn, M.D.
JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

L7

STATE OF COLORADO

Department of Regulatory Agencies
Division Of Registration

SEE INSTRUCTIONS ON REVERSE

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690 V/TDD (303) 894-7880

REPORT OF PRACTICE HISTORY
ORIGINAL LICENSURE

	Facility Name	Address and Zip	Reference (name & title)	Dates of Practice From – To MO/YR – MO/YR	Nature of Practice
1.	Sinai Sammaritan Med. Ctr	945 N. 12th Street Milwaukee, WI 53201	Dr. Brokhausen Program Director OB/GYN	6/95-12/95	OB/GYN / Internal Med Internship
2.	Regions Hospital	640 Jackson Street St. Paul, MN 55101	Dr. Carol Ball Program Director OB/GYN	1/96-5/96	OB/GYN Internship
3.	Medical LOA	Medical leave of Absence for 1 year- Required amputation of Right Foot secondary to injury sustained in MVA in 1991		6/96-3/97	Medical LOA
4.	Regions Hospital	640 Jackson Street St. Paul, MN 55101	Dr. Charles Bloomquist Director of OB/GYN Research	3/97-6/97	Research Assistant
5.	Regions Hospital	640 Jackson Street St. Paul, MN 55101	Dr. Carol Ball Program Director OB/GYN	6/97-6/98	OB/GYN Internship
6.					
7.		BOARD OF MEDICAL EXAMINERS			
8.		JUL 27 1998			
9.		STATE OF COLORADO			
10.					

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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.

L6

SIGNATURE

ALLEN
PRINT LAST NAME

7/20/98
DATE