

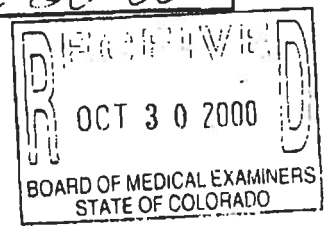
APD6812

COLORADO STATE BOARD OF MEDICAL EXAMINERS
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.

1 a. Name: Last <u>Nagle</u> First <u>Melinda</u> Middle <u>Lee</u> Degree <u>MD</u>				1b. Social Security Number _____		OFFICE USE ONLY PERSONAL DATA <input type="checkbox"/> L7
2. Other names (i.e. maiden name)- indicate if none.						
3. Mailing Address: Number and Street/Rural Route, Apartment Number _____ (NOTE, Address provided is, by law, public information.)						<input type="checkbox"/> BC
<input checked="" type="checkbox"/> Home <input type="checkbox"/> Business						
City _____		State _____		Zip _____		Country _____
e-mail address: _____						<input type="checkbox"/> MED EDUC
4. Telephone Number: (Area Code) _____ Day _____ Evening _____			5. Date of Birth: _____		Place of Birth _____	
submit a copy of your birth certificate or passport						
6. Sex Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>		7. Have you ever filed an application in Colorado? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, give date of previous application _____				<input type="checkbox"/>
8. List name/address of the school where pre-medical degree was received.						
Name of School <u>UC-Berkeley</u>		Address and Zip <u>Berkeley California</u>		Period of Attendance From (Mo/Yr) <u>8/85</u> To (Mo/Yr) <u>5/89</u>		<input type="checkbox"/>
9. 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 <u>New York Medical College</u>		Address and Zip <u>Valhalla NY 10595</u>		Period of Attendance From (Mo/Yr) <u>8/93</u> To (Mo/Yr) <u>5/97</u>		<input type="checkbox"/>
10. 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
<u>USMLE Step I</u>		<u>Denver Colorado</u>		<u>4/95</u>		_____
<u>USMLE Step II</u>		<u>New York</u>		<u>3/97</u>		_____
<u>USMLE Step III</u>		<u>Los Angeles</u>		<u>1/98</u>		_____

Official Use Only	License # <u>39222</u>	Date <u>12-07-00</u>
Revised 10/99	Fee \$ <u>375</u>	Date: <u>10-30-00</u>



11. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs? <input checked="" type="checkbox"/> Yes If yes, provide Information below. <input type="checkbox"/> No					POSTGRAD TRAINING <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Name of program	Institution	Specialty	Period of attendance			
Cedars Sinai	Cedars Sinai (MS.P) (M)	OB/GYN	From (Mo/Yr)	To (Mo/Yr)		
			6/97	Present		
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. <input checked="" type="checkbox"/> Yes If yes, provide information below. <input type="checkbox"/> No					LICENSE DATA <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
State or country	License #	Issue date	Dates of Practice in this jurisdiction			
California	A067894	4/99	From (Mo/Yr)	To (Mo/Yr)		
			Residency -	6/97-present		
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? <input type="checkbox"/> Yes If yes, give details below. <input checked="" type="checkbox"/> No					REQ REC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
State	Date	Charge	Disposition			

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?

23. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been canceled or rated at a higher premium due to past claims experience? <input type="checkbox"/> Yes, If yes, explain on a separate sheet and provide verification from insurance company or state licensing board. <input checked="" type="checkbox"/> No	REQ REC <input type="checkbox"/> <input type="checkbox"/>
24. 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: <u>I currently reside outside of Colorado and claim "d", set form in attached rule. I understand before I engage in medical practice in Colorado I must obtain the required insurance or acceptable equivalent.</u>	INS <input type="checkbox"/>

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, Melinda L. Nagle 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.

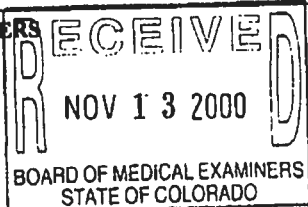
I understand that under the Colorado Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license and that application fees are not refundable.

Melinda L. Nagle MD Signature
8/11/00 Date

RETURN THIS APPLICATION TO:
COLORADO BOARD OF MEDICAL EXAMINERS
1560 BROADWAY, SUITE 1300
DENVER CO 80202-5140

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



CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Melinda L. Nagle
FULL NAME OF APPLICANT
enrolled in New York Medical College
FULL NAME OF MEDICAL SCHOOL
Valhalla New York on the 17 day of August 1993
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 3rd day of August, 1993 and was granted the degree
Bachelor/Doctor of Medicine or ~~Doctor of Osteopathy~~ on the 19th day of May, 1997.

Signed and the college seal affixed

This 2nd day of November, 1900

By Barbara W. [Signature] Associate Dean & Registrar

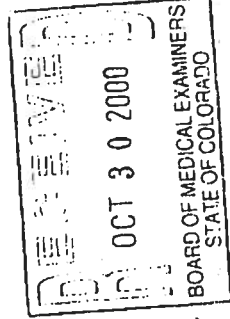
NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:

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

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STATE OF COLORADO



Department of Regulatory Agencies
Division of Registrations

STATE BOARD OF MEDICAL EXAMINERS

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<http://www.dora.state.co.us/medical>

REPORT OF PRACTICE HISTORY

Facility Name	Address and Zip	Reference (name and title)	Dates of Practice From-to	Nature of Practice
1. Cedars-Sinai Hospital	8700 Beverly Blvd. Los Angeles CA 90048	Lawrence Platt Chairman OB/GYN	1997 - Present	Residency
2.				
3.				
4.				
5.				
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 18-6-503, 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.

Marilyn Nagle
SIGNATURE

Nagle
PRINT LAST NAME

8/11/00
DATE

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