Licensee Information

Licensee Name	**Allen Palmer**
License Number	**05-33326**
License Type	**DO**
License Designation (status)	**Active**

Payment Information

Confirmation Number	**4517584**
Reference ID	**b3505a19f6d5403**
Transaction Date	**Sep 19, 2012 2:17:22 PM**
Payment Method	**Credit Card**
Kansas.gov Purchase Price	**331.50**

Practice in Kansas

Do you actively practice in Kansas?	Yes
Are you planning to retire within the next 5 years?	(Not Provided)
Is your name (shown near the top of this page) and spelling correct?	Yes
If you have an NPI # (National Provider/Identifier) enter it here.	1447322805
Do you dispense prescription medications in Kansas?	No
DEA Registration Numbers	ap5614955 fp0364656

Want Change License Designation

Do you want to change your license designation?	No

Practice Specialty

Primary practice specialty	Obstetrics/Gynecology

Board Certifications

Are You board Certified?	Yes

Board Certifications

Board Certification 1

Certifying Board	American College of Osteopathic Obstetricians and Gynecologists
Certified Specialty	Obstetrics and Gynecological Surgery

Practice in other states

Do you actively practice in any state other than Kansas?	Yes
All states in which you have a license:	IL,KS,MO

Residence Address

Street Address	Confidential
Secondary Street Address	(Not Provided)
City	CLAYTON
State	Missouri
Zip Code	63105
County	None
Country	United States
Phone Number	Confidential
Email	Confidential

Mailing Address

Street Address	Confidential
Secondary Street Address	(Not Provided)
City	CLAYTON
State	Missouri
Zip Code	63105
County	None
Country	United States

Business Addresses

Business Address 1

Name	COMPREHENSIVE HEALTH PPKM
Street Address	4401 W 109TH STREET
Secondary Street Address	(Not Provided)
City	Leawood
State	Kansas
Zip Code	66211
County	Johnson
Country	United States
Phone	9133451400
Fax	9133452820
ABOUT THIS LOCATION	
What kind of work setting is this business site?	(Not Provided)
How many patients do you see during an average week at this site?	25
How many hours of direct patient care do you provide at this work site in a typical week?	6
How many weeks per year do you work here?	15
As part of your direct patient care scope of practice, do you or any of your staff provide immunizations?	(Not Provided)
As of today, how many hours is it until the next available appointment time at this practice location?	(Not Provided)
Are you accepting new patients at this practice location?	(Not Provided)
Of the patients you see during an average week at this practice location, what percentage are Medicaid recipients?	(Not Provided)
Of the patients you see during an average week at this practice location, what percentage use a sliding fee schedule based on income or ability to pay?	(Not Provided)
Percentage of time spent in direct patient care in "Obstetrics/Gynecology"?	100

Disciplinary Questions

A. In the past 12 months have you been a defendant or has any judgment, award, or settlement been paid resulting from a professional liability claim?	No
B. In the past 12 months have you been arrested, charged with or convicted of any felony or class A misdemeanor?	No
C. In the past 12 months has any disciplinary action been initiated or taken against you by a state licensing agency or other state or government agency, or have you surrendered or consented to limitation of license to practice in any state or country?	No
D. In the past 12 months have any privileges related to your profession as a healthcare provider been suspended, restricted, limited or voluntarily surrendered or has any peer review or professional association initiated or taken any action against you?	No
E. In the past 12 months have you suffered from any impairment, which might affect your ability to safely practice?	Confidential
F. In the past 12 months do you know of any investigation by or any allegations, complaints, or charges concerning you made to any licensing agency or state or government agency?	No

Public Profile

Do you wish to add a statement to your public profile? This statement must be received by the Board within 30 days after your license expiration date.	No

Demographic Information

Gender:	Male
Race:	(Not Provided)
Are you of Hispanic or Latino origin?	(Not Provided)
What languages do you speak?	(Not Provided)
Are you a graduate of a foreign professional school?	No
Are you a citizen or permanent resident of the United States?	Yes
How many hours of direct patient care do you provide in Kansas in a typical week?	4
How many total direct patient care sites do you have in Kansas?	1
Does your main office use an Electronic Health Record (EHR) system?	Yes

Is your current EHR system certified by The Office of the National Coordinator for Health Information Technology at the U.S. Department of Health and Human Services?	Yes

Volunteer Services

I am willing to be included on a registry to provide my services during an emergency.

Within your county of residence	No
Within 75 miles of your residence	No
Anywhere in the State of Kansas	No
Outside of the State of Kansas	No

Continuing Education Requirements

Education Hours Required	50 hours in the past year
Have you completed the required hours?	Yes
Do you understand and agree to the audit procedures?	Yes

Malpractice Review Committee

Are you willing to serve on a malpractice screening panel?	No

Professional Liability Insurance

Policy Number	ksp0019878
Insurer	Other (Please Specify) KS Medical Mutual Insurance Co
Policy Effective Date	11/01/2011
Policy Expiration Date	11/01/2012

Office-Based Surgery

Do you perform any procedure in your office that requires sedation, including: IV sedation of any kind; inhaled agents; parenteral, regional, spinal, epidural or general anesthesia?	Yes

Hospitals

	OVERLAND PARK REGIONAL MEDICAL CTR

Supervise

Do you directly supervise any licensed professional Physician Assistant(s), Athletic Trainer(s) and/or Licensed Radiologic Technologists?	No
HAVE YOU SUBMITTED A CURRENT COPY OF THIS FORM?	

Supervision over non-Licensed Radiologic Technologists

Do you supervise any person(s) performing radiological technology procedures who are not licensed as radiologic technologists?	No
Do you certify that they have been trained on the equipment?"	(Not Provided)
Do you certify that they have or will have obtained continuing education as required by K.A.R. 100-73-9?	(Not Provided)

Renewal Filer

Are you the licensee named upon the license?	Yes

Perjury

I hereby certify that I am the licensee named in this renewal application, and I have personally submitted all data requested in the renewal application form. I declare under penalty of perjury that I have read the application form and my responses, and that the information I have provided is true, correct and complete to the best of my knowledge. I understand that Kansas statutes allow the State Board of Healing Arts to revoke, suspend or limit a license, or censure the licensee, or impose fine in an amount up to $ 5,000 for any act of fraud or misrepresentation in applying for renewal of a license.	I Agree