Licensee Information

Full Name	Allen S. Palmer
License Number	05-33326
License Code	DO
License Designation	ACT
Renewal Year	2014

Payment Information

Payment Status	SUCCESS
Confirmation Number	3649492
Reference ID	B35214D07EBE8E9
Transaction Date	8/21/13 9:42 AM
Payment Method	CREDIT_CARD
Kansas.gov Purchase Price	$331.50

About You and Your Practice

Do you actively practice in Kansas?	**Yes**
Have you retired or are you planning to retire in the next 5 years?	**No**
Is your name and spelling above correct?	**Yes**
NPI #	**1447322805**
Do you dispense prescription medications in Kansas?	**Yes**
Registration Number 1	**FP2568167**
Registration Number 2	**AP5614955**
Registration Number 3	**FP0364656**
Registration Number 4	Not Provided
Registration Number 5	Not Provided

License Designations

Do you want to change your license designation?	**No**

Practice Specialty

Primary Specialty	**Obstetrics/Gynecology** (30)
Second Specialty	Not Provided
Third Specialty	Not Provided

Board Certified

Are you Board Certified?	**Yes**

Board Certifications

Board Certification 1

Certifying Board Name	**ACOOG**
Specialty Name	**Ob\Gyn**

Practice in other states

Do you actively practice or have you ever held a license in any state other than Kansas?	**Yes**
Select up to 5 states other than Kansas in which you have a license.	**Illinois** (IL) **Missouri** (MO)

Residence Address

Is your Mailing Address the same as your Residence address?	**Yes**
Street Address Line 1	Confidential
Street Address Line 2	Not Provided
City	**CLAYTON**
State	**Missouri** (MO)
Zip Code	**63105**
County	**out of state**
Country	**UNITED_STATES**
Phone Number	Confidential
Email	Confidential
I have reviewed and verified that all of the information above is accurate.	**Yes**

Mailing Address

Your Residence Address will be provided as your Mailing Address	**I Agree**

Business Addresses

Business Address 1

Business Name	**COMPREHENSIVE HEALTH PPKM**
Street Address Line 1	**4401 W 109TH STREET**
Street Address Line 2	Not Provided
City	**Leawood**
State	**Kansas** (KS)
Zip Code	**66211**
County	**Johnson** (JO)
Phone	**913-345-1400**
Fax	**913-345-2820**
What kind of work setting is this business site?	**3**
How many patients do you see during an average week at this site?	**9**
How many hours of direct patient care do you provide at this work site in a typical week?	**4**
How many weeks per year do you work here?	**14**
Other Setting	Not Provided
As part of your direct patient care scope of practice, do you or any of your staff provide immunizations?	**No**
As of today, how many hours is it until the next available appointment time at this practice location?	**24**
Are you accepting new patients at this practice location?	**Yes**
Of the patients you see during an average week at this practice location, what percentage are Medicaid recipients?	**15**
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?	**0**
Percentage of time in direct patient care in the specialty Obstetrics/Gynecology	**100**
I have reviewed and verified that all of the information above is accurate.	**Yes**

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 have you been the subject of any investigation regarding allegations, complaints or charges by any state licensing agency or other 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**

Demographics

Gender	**Male** (M)
Race	
White	**Yes**
Black or African American	**No**
Hispanic or Latino	**No**
American Indian or Alaskan Native	**No**
Asian	**No**
Native Hawaiian	**No**
Other (if selected specify in the other race field)	**No**
Other Race	Not Provided
What languages do you speak?	
English	**Yes**
Spanish	**Yes**
Sign Language	**No**
Other (if selected specify in the other language field)	**No**
Other Language	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

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**

Malpractice Review Committee

Are you willing to serve on a malpractice screening panel?	**Yes**
Are you willing to serve as an expert for the Board in a licensing disciplinary case?	**No**

Continuing Education Requirements

Completed CEU Requirements	**50 hours 04/01/2012 through 09/30/2013** (1)
I have completed the required hours?	**Yes**
I understand and agree to the audit procedures?	**Yes**

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**

Kansas Hospitals

Indicate up to 5 hospitals at which you have privileges. If you have more than 5, send your information to KSBHA.	**Overland Park Regional Medical Ctr** (H046003)

Supervision over Non-Licensed Radiologic Technologists

Do you supervise any person(s) performing radiological technology procedures who are not licensed in Kansas 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

Whom You Supervise

Do you directly supervise any licensed professional Physician Assistant(s) and/or Athletic Trainer(s)?	**No**

Professional Liability Insurance

Policy Number	**ksp0019878**
Insurer Id	**Kansas Medical Mutual Ins. Co.** (2120)
Other Insurer	**1**
Policy Effective Date	**11/01/2012**
Policy Expiration Date	**11/01/2013**
I understand and agree with the Board of Healing Arts audit procedures?	**Yes**

Renewal Filer

Are you the licensee named on the license?	**Yes**
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**
Enter your full name	**Allen Palmer**