STATE OF COLORADO

912

Department of Regulatory Agencies
Division of Registrations

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

BOARD OF MEDICAL EXAMINERS
MAR 24 1995
STATE OF COLORADO

FEB 28 1995
STATE OF COLORADO

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.**

OFFICE USE ONLY

1a. Name: Last: BORGATTA First: LYNN Middle: — Degree: MD, MPH

1b. Social Security Number: [redacted]

PERSONAL DATA
EPC sent: ☐
FED sent: ☐

2. Other names - indicate if none.
none

3. Mailing Address: Number and Street/Rural Route, Apartment Number
175 TARRYTOWN RD

City: WHITE PLAINS State: NY Zip: 10607 Country:

4. Telephone Number: (Area Code) Day / Evening
W 914-428-7876
H 914-693-5005

5. Date of Birth: Mo/Day/Year: 10/18/50 Place of Birth: New York
Submit a certified or notarized copy of your birth certificate or passport. ☑

6. Sex
☐ Male ☒ Female

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

PRE-MED EDUC

8. List name and address of all colleges or universities where pre-medical instruction was received. Pre-medical instruction is limited to that course work required for entrance to medical school.
Request an official copy of transcript, with seal of school affixed, to be sent directly from the school to this office.
If transcripts are not in English, send a certified English translation.

Name of school	Address and zip	Period of attendance: From (Mo/Yr)	To (Mo/Yr)
University of Wisconsin	Madison, Wisconsin	9/66	1/70

☑ ☐

MEDICAL EDUC
CME ☑

9. List name and address of all schools where professional medical instruction was received.
Request an original L2 Form (Certificate of Medical Education) and an official copy of transcripts, with seal of school affixed, from each school attended. Certificate and transcripts must be sent directly from the school to this office.
If transcripts are not in English, send a certified English translation.

Name of schoo	Address and zip	Period of attendance From (Mo/Yr)	To (Mo/Yr)
A. Einstein College of Medicine	1300 Morris Pk Ave Bronx, NY 10461	9/70	6/74

☑ ☐ ☐ ☐ ☐

DPL ☑

10. Doctor of Medicine/Osteopathy Degree granted by: (Submit legible photocopy)
If degree is not in English, send a certified English translation.

Name of medical school	Address and zip	Date degree conferred
A Einstein College of Medicine	1300 Morris Pk Ave Bronx, NY 10461	1974

License # 34299 Date 5/3/95

Fee $ 329 Date 2/28/95

Org. 8/86
Revised 9/92

L1A

11. Have you taken any of the following written examinations: National Boards, ECFMG, FLEX, LMCC, USMLE, or state written exam? ☒ Yes ☐ No

If yes, request certification of scores from each examination agency to be sent directly from examination agency to this office. (See "Summary of Requirements"). Provide photocopy of ECFMG Certificate if applicable. Provide information below:

Exam	Location	Date	Result
National Boards	? New York	1975 for Part 3	passed

WRITTEN EXAM ☑

12. 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)
Roosevelt Hospital	W 59th + 9th Ave	Surgery (not completed)	7/74	6/76
St. Luke's Hospital	1111 Amsterdam Ave	Ob/Gyn	6/76	6/79
	NY NY 10025			

POSTGRAD TRAINING ☑ ☑ ☐

13a. Are you now or have you ever been licensed to practice medicine in any state, territory, district, or country? (See L4 Form) ☒ Yes ☐ No Include temporary licenses and instructional permits.

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)
New York	125870	1975	7/74 (intern)	present

LICENSE DATA ☑ ☐ ☐ ☐ ☐ L4 ☐ L6 ☐

13b. 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? (See L6 Form) ☒ Yes ☐ No

14. 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? no If yes explain on a separate sheet and provide verification of same from insurance company or state licensing board.

15. Have you ever been notified by any state, territory, district, country, U.S. government agency, state medical/osteopathic board of **any complaint** against you relative to the practice of medicine? This includes, but is not limited to, any allegations currently pending. ☐ Yes ☒ No

If yes, give details below:

State	Date	Charge	Disposition

REQ REC ☐ ☐ ☐ ☐ ☐ ☐

16. 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

17 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 U.S. federal jurisdiction?

☐ Yes ☒ No

If yes, give details below:

State or government agency	Date	Reason for denial

LICENSE DATA (continued)

REQ REC ☐ ☐ ☐ ☐

18. Have you ever voluntarily surrendered a license to practice in the healing arts in any other state? This does not include allowing your license to lapse solely due to payment of the renewal fee.

☐ Yes ☒ No

If yes, explain on a separate sheet. Summarize below:

State	Date	Reason for surrender

REQ REC ☐ ☐ ☐ ☐

19. Have you ever had staff privileges in a hospital limited or reduced, denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action?

☐ Yes ☒ No

If yes, explain on a separate sheet. Provide a copy of letter of resignation or hospital action. Summarize details below:

Name of facility	Address and zip	Date	Reason for Action

REQ REC ☐ ☐ ☐ ☐

20. Do you now have, or have you ever had, a physical or mental condition which might affect your ability to practice medicine?

☐ Yes ☒ No

If yes, explain on a separate sheet. Give dates of onset, description of condition, description of treatment, name and address of treater, current status of condition.

GENERAL DATA

REQ REC ☐ ☐

21. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, prescription medication or alcohol?

☐ Yes ☒ No

If yes, explain on a separate sheet of paper. If treated, give name, address and zip of both facility and treater, dates of treatment, current status of condition.

REQ REC ☐ ☐

22. Have you ever received a deferred prosecution, a deferred judgement, been convicted of, or pled guilty or **nolo contendere** to a violation of any federal, state, or local law relating to the manufacture, distribution or dispensing of controlled substances, or relating to drug abuse, including alcohol?

☐ Yes ☒ No

If yes, explain on a separate sheet. Summarize below:

Date	Court address and zip	Violation	Penalty or disposition

REQ REC ☐ ☐ ☐ ☐

23. Have you ever received a deferred prosecution, a deferred judgement, been convicted of or pled guilty or **nolo contendere** to, any felony in any state, territory, district, the United States, or a foreign country?

☐ Yes ☒ No

If yes, give details below: Include any conviction that has been set aside, dismissed, or pardoned under the Constitution of Colorado, article IV, section 7, or under any other provision of law.

Date	Court address and zip	Violation	Penalty or disposition

REQ REC ☐ ☐ ☐ ☐

24. You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado law, or state basis for exemption. See instructions in application packet.

INS ☐

I hereby declare under penalty of perjury under the laws of the State of Colorado, that the photo of myself attached hereto, was taken

on or about 2/15, 19 95,

my age then being 44 years;

color of hair brown;

color of eyes hazel;

height 5 ft. 5 in.;

weight 133 lbs.;

identifying marks _____

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, LYNN BORGATTA 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 that 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

2/21/95
Date

Wanda Registrar 1965

1974

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

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

BOARD OF MEDICAL EXAMINERS
FEB - 3 1995
STATE OF COLORADO

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW.

This certifies that LYNN BORGATTA
FULL NAME OF APPLICANT

of Rupert, Vermont enrolled in Albert Einstein College of Medicine
ADDRESS WHEN ENROLLED NAME OF MEDICAL SCHOOL

1300 Morris Park Avenue, Bronx, N.Y. on the 8th day of September, 19 70
LOCATION MONTH YEAR

and was granted the following credits on enrollment:

Course of study	Institution	Date completed	Credit awarded
MEDICINE	ALBERT EINSTEIN COLLEGE OF MEDICINE	5/23/74	

The undersigned further certifies that the records of this institution show that ~~s~~he attended in this institution ALL 4 Years of ~~XXXXXXXXX~~ resident instruction, and that:

☒ s/he was granted the degree ~~Bachelor~~/Doctor of Medicine ~~or Doctor of Osteopathy~~

☐ s/he withdrew from
the above mentioned medical/~~osteopathic~~ school on the 23rd day of May, 19 74

Signed and the college seal affixed this 31st day of January, 19 95

BY Mrs. Lillian Lombardi, Registrar
~~XXXXXXXXXXXXXXXX~~

NOTES TO REGISTRAR AND APPLICANT

1. Medical School Seal **MUST** Be Imprinted Partially on the Photograph.
2. TRANSCRIPTS OF MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE.
3. Each school where professional medical instruction was received **MUST** complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to the form must be original.

NOT VALID WITHOUT SCHOOL SEAL

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

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BOARD OF MEDICAL EXAMINERS
FEB 21 1995
STATE OF COLORADO

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

TO BE COMPLETED BY APPLICANT:
(Please type or print neatly.)

1. NAME (last) (first) (middle): BORGATTA LYNN -

2. ADDRESS: Number and street/rural route (include apt. no., if any): 175 TARRYTOWN RD

CITY: WHITE PLAINS | STATE: NY | ZIP CODE: 10607-1616 | COUNTRY:

3. DATE OF BIRTH: mo/day/yr	4. SEX:	5. STATE LICENSING AGENCY
10/18/50	☒ Female ☐ Male	NY St. Education

6. LICENSE NUMBER	7. DATE OF ISSUANCE:	8. DATE OF EXPIRATION
125870	1975	1996

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.

Lynn Borgatta — SIGNATURE

1/26/95 — DATE

TO BE COMPLETED BY STATE LICENSING AGENCY: **(Do not complete if photograph of applicant is not attached above. Please type or print.)**

I certify that _____ (NAME OF APPLICANT) who graduated from _____ (NAME OF MEDICAL SCHOOL) on _____ (DATE OF GRADUATION) was granted license number _____

on _____ (DATE LICENSE ISSUED) on the basis of _____ (FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM) National Board exam

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Issued on Credentials.

I further certify that this doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE)

and obtained a general average of _____ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

Is this license valid & current? _____ Has it ever been suspended or revoked? _____ When does it expire? _____ (date)

According to your records, are there now or have there ever been any charges filed against this licensee? _____ Is there any investigation pending regarding this licensee? _____ IF THIS APPLICANT'S RECORD IS NOT COMPLETELY CLEAR IN REGARD TO THESE QUESTIONS, PLEASE ATTACH AN EXPLANATION.

NOT VALID WITHOUT SEAL

(AFFIX LICENSING AGENCY SEAL)

TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL

SIGNATURE OF AGENCY OFFICIAL

DATE

NAME OF STATE LICENSING AGENCY

ADDRESS

PHONE NUMBER

RECEIVED
FEB 13 1995
RAU

L4

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

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

BOARD OF MEDICAL EXAMINERS
FEB 21 1995
STATE OF COLORADO

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

TO BE COMPLETED BY APPLICANT:
(Please type or print neatly.)

1. NAME (last) (first) (middle): BORGATTA LYNN -
2. ADDRESS: Number and street/rural route (include apt. no. if any): 175 TARRYTOWN RD
   CITY: WHITE PLAINS, STATE: NY, ZIP CODE: 10607-1616, COUNTRY:
3. DATE OF BIRTH: mo/day/yr: 10/18/50
4. SEX: ☒ Female ☐ Male
5. STATE LICENSING AGENCY: NY St. Education
6. LICENSE NUMBER: 125870
7. DATE OF ISSUANCE: 1975
8. DATE OF EXPIRATION: 1996

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.

Lynn Borgatta — SIGNATURE
1/26/95 — DATE

TO BE COMPLETED BY STATE LICENSING AGENCY: **(Do not complete if photograph of applicant is not attached above. Please type or print.)**

I certify that _____ (NAME OF APPLICANT) who graduated from _____ (NAME OF MEDICAL SCHOOL) on _____ (DATE OF GRADUATION) was granted license number _____

on _____ (DATE LICENSE ISSUED) on the basis of _____ (FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM) national board exam

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Issued on Credentials.

I further certify that this doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE)

and obtained a general average of _____ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

Is this license valid & current? _____ Has it ever been suspended or revoked? _____ When does it expire? _____ (date)

According to your records, are there now or have there ever been any charges filed against this licensee? _____ Is there any investigation pending regarding this licensee? _____ IF THIS APPLICANT'S RECORD IS NOT COMPLETELY CLEAR IN REGARD TO THESE QUESTIONS, PLEASE ATTACH AN EXPLANATION.

NOT VALID WITHOUT SEAL

(AFFIX LICENSING AGENCY SEAL)

TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL

SIGNATURE OF AGENCY OFFICIAL

DATE

NAME OF STATE LICENSING AGENCY

ADDRESS

PHONE NUMBER

RECEIVED
FEB 18 1995
RAU

L4

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

STATE OF COLORADO

INSTRUCTIONS:

1. List all of your experience in medical practice in chronological order since medical school including all post-residency training programs. List all hospitals in which you held privileges for the last five years. Include temporary privileges and locum tenens positions. If you have not practiced medicine for one month or greater, explain activities during that time. Complete all blanks. "Date of Practice" should include beginning month and year and ending month and year.

2. Request an original letter of verification for each hospital staff, clinic, private practice, or any other medical practice and post residency training programs or any other medical position held during the last five years. Each letter should be written by the chief of staff or chief administrative officer. If in private practice, provide a letter written by an associate or colleague. All letters must verify dates of practice (include beginning month and year and ending month and year), nature of practice, and privilege status. Each letter must also include an evaluation of your skill level, aptitude, ability to apply knowledge, and an assessment of your attitude and behavior toward your colleagues and patients. If contracted by locum tenens agency, one letter from that agency verifying all positions held will suffice.

	Facility Name / Address and Zip	Reference (name & title)	Date of Practice From: Mo/Yr — To: Mo/Yr	Nature of Practice
1.	Roosevelt Hospital 555 W. 57th St. NY, NY 10019	Horse staff office (L3 requested)	7/79 - 6/76	residency general surgery
2.	St. Luke's-Women's Hospital 114th St + Amsterdam Ave NY, NY 10025	Horsestaff Office (LB requested)	7/76 - 6/80	residency obstetrics and gyn
3.	Montefiore Hospital Center 111 E 210th St Bronx, NY 10467	Irwin Merkatz, MD Chairman Dept Ob/Gyn	7/79 - 6/88	full-time hospital based faculty, general obstetrics and gynecology payroll switch in '88
4.	Albert Einstein College of Medicine 1300 Morris Park Ave Bronx, NY 10461		7/88 - 8/89	
5.	Westchester County Medical Center Valhalla, NY 10595	James Jones, MD Chairman, Dept Ob/Gyn	9/89 - present	9/89 - 6/94 - half time faculty 7/94 - present - faculty
6.	Planned Parenthood of Westchester and Rockland Inc 175 Tarrytown Rd White Plains, NY 10607	Francine Stein MPA Executive Director	9/89 - present	medical director (supervision, training and clinical practice)
7.				
8.				
9.				
10.				

BOARD OF MEDICAL EXAMINERS
FEB 28 1995
STATE OF COLORADO

L6

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.

W Butler MD / L Borgatta — SIGNATURE — 1/26/95 — DATE

LYNN BORGATTA — PRINT NAME

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CUSTOMER SERVICE UNIT
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

BOARD OF MEDICAL EXAMINERS

FEB 21 1995

STATE OF COLORADO

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, BORGATTA LYNN
WAS ISSUED LICENSE/CERTIFICATE NUMBER 125870 FOR THE PRACTICE OF MEDICINE ON 11/10/75.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: 10/18/50
SCHOOL ATTENDED: ALBERT EINSTEIN MED COL
DATE OF GRADUATION: 05/01/74
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:
B NATIONAL BOARD CERT #145328 DATED 07/01/75

NP #330452/#360199/NP #420276/NP #330644/NP #420283
NP(33)#000139/NP(33)#000371/NP(33)#000506/NP(42)#000210
NP(42)#000165/NP(42)#000067/NP(42)#000182/NP(33)#000411
NP(33)#000077/NP(36)#000026/NP(42)#000037/NP(42)#000102
NP(42)#000155/NP(33)#000067/NP(33)#000111/NP(33)#000076
NP(42)#000132[X]MORE

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: YES REG PERIOD ENDS: 09/30/96
ADDRESS: 175 TARRYTOWN ROAD WHITE PLAINS NY 10607-1616

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I FRANCES HARRIS, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

Frances Harris 02/14/95
PRINCIPAL CLERK

026 028

1999 RENEWAL INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility

☐ **I WISH TO CHANGE FROM INACTIVE TO ACTIVE STATUS: FEE - $305.** You must complete a different form Please call the Board Office at (303) 894-7719 to request a Reactivation Form

☐ **ACTIVE LICENSE: FEE - $305** I wish to renew my license via ACTIVE STATUS. I meet (or claim exemption from) the financial responsibility standards as indicated below· **You must check at least one.**

☐ 1. I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year.

Company: COPIC ☐ **Doctors Company** ☐ **St. Paul** ☐ **Other (Specify_____)**

NOTE: Please supply your insurance policy number: _____

☐ 2. I am covered by individual commercial professional liability insurance maintained by an employer/contracting agency in accordance with the requirements noted in "1" above

☐ 3. I am a federal civilian or military physician whose practice is limited solely to that required by my federal or military agency

☐ 4 I am a public employee whose practice is limited solely to that covered by the Colorado Governmental Immunity Act.

☐ 5 I do not engage in any patient care whatsoever within the state of Colorado, including prescribing. I am, however, engaged in active medical practice in another state or foreign jurisdiction (NOTE: You may wish to consider renewing your license via inactive status - see below)

☐ 6 My medical practice does not involve any patient care whatsoever (e g , administrator, researcher, academician, non-medical endeavor (NOTE· You may wish to consider renewing your license via inactive status - see below)

☐ 7 I provide limited or occasional, uncompensated care to patients and I do not otherwise provide any compensated patient care whatsoever

☐ 8 I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance. (Must have approval from the Colorado Commissioner of Insurance. See note below)

☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

NOTE· The Commissioner of Insurance approves alternatives for financial responsibility. Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used The address of the Commission Office is 1560 Broadway, Suite 850, Denver, Colorado 80202 (303) 894-7499

MAKE CHECKS PAYABLE TO: COLORADO BOARD OF MEDICAL EXAMINERS

☒ **INACTIVE LICENSE FEE - $150** I wish to renew my license via INACTIVE STATUS. (NOTE: this category is primarily intended for retired physicians and those practicing outside Colorado) Malpractice insurance is not required for inactive license holders. **I understand that I may not practice medicine, including prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional $155.00. I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.**

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 of Physician	Date	Phone #	Fax ##
[signature]	4/15/99	617 414 5593	617 414 7300

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee, and 3) the Physician Survey (optional) in the enclosed return envelope. Direct questions to· **(303) 894-7719 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver, CO 80202-5140**

1997 RENEWAL INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility.

☐ **I WISH TO CHANGE FROM INACTIVE TO ACTIVE STATUS: FEE - $195.** You must complete a different form Please call the Board Office at (303) 894-7719 to request a Reactivation Form

☐ **ACTIVE LICENSE: FEE - $195.** I wish to renew my license via ACTIVE STATUS I meet (or claim exemption from) the financial responsibility standards as indicated below: **You must check at least one.**

☐ 1. I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year

Company: COPIC ☐ **Doctors Company** ☐ **St. Paul** ☐ **Other (Specify_____)**

NOTE: Please supply your insurance policy number: _____

☐ 2 I am covered by individual commercial professional liability insurance maintained by an employer/contracting agency in accordance with the requirements noted in "1" above.

☐ 3. I am a federal civilian or military physician whose practice is limited solely to that required by my federal or military agency.

☐ 4 I am a public employee whose practice is limited solely to that covered by the Colorado Governmental Immunity Act

☐ 5. I do not engage in any patient care whatsoever within the state of Colorado, including prescribing I am, however, engaged in active medical practice in another state or foreign jurisdiction (NOTE: You may wish to consider renewing your license via inactive status - see below)

☑ 6 My medical practice does not involve any patient care whatsoever (e g , administrator, researcher, academician, non-medical endeavor (NOTE You may wish to consider renewing your license via inactive status - see below)

☐ 7 I provide limited or occasional, uncompensated care to patients and I do not otherwise provide any compensated patient care whatsoever

☐ 8 I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance

☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

NOTE The Commissioner of Insurance approves alternatives for financial responsibility. Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used. The address of the Commission Office is: 1560 Broadway, Suite 850 Denver, Colorado 80202· (303) 894 7499

☑ **INACTIVE LICENSE FEE: $100** I wish to renew my license via INACTIVE STATUS. (NOTE: this category is primarily intended for retired physicians and those practicing outside Colorado) Malpractice insurance is not required for inactive license holders **I understand that I may not practice medicine, including prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license. I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional $95.00. I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.**

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 of Physician	Date	Phone #	Fax ##
[signature]	6/23/97	212 261 4704	212 247 6269

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee, and 3) the Physician Survey (optional) in the enclosed return envelope Direct questions to **(303) 894-7690 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver, CO 80202-5140**

2001 LICENSE RENEWAL QUESTIONNAIRE AND INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility Please be advised, you CANNOT use this renewal form to change your status from FROM INACTIVE TO ACTIVE You must complete a reactivation application to reactivate your license Please call the Board Office at (303) 894-7690 to request a reactivation application This is a process separate and independent from the renewal process

☐ ACTIVE LICENSE FEE - $315 I wish to renew my license in ACTIVE STATUS I meet (or claim exemption from) the financial responsibility standards as indicated below You **must check at least one.**

- ☐ I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year

  ☐ COPIC ☐ Doctors Company ☐ St Paul ☐ Other (Specify)_____

  NOTE Please supply your insurance policy number _____

- ☐ I am a federal civilian or military physician whose practice is limited solely to that required by my federal/military agency
- ☐ I am a physician who is not engaged in the practice of medicine
- ☐ I am a physician who is covered by individual commercial professional liability coverage (or an alternative which complies with Section 13-64-301(1)(c), (d) or (e)) maintained by an employer/contracting agency in the amounts set forth above.
- ☐ I am a physician who provides uncompensated health care to patients, or who does not otherwise engage in any compensated patient care in Colorado
- ☐ I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance (Must have approval from the Colorado Commissioner of Insurance See note below)

  ☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

NOTE The Commissioner of Insurance approves alternatives for financial responsibility Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used The address of the Commission Office is 1560 Broadway, Suite 850, Denver, Colorado 80202 (303) 894-7499

☒ INACTIVE LICENSE FEE - $160 I wish to renew my license in INACTIVE STATUS Malpractice insurance is not required for inactive license holders **I understand that I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license.** I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations

MAKE CHECKS PAYABLE TO: COLORADO BOARD OF MEDICAL EXAMINERS

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

W Borgatta 4/25/01

Signature of Physician **Date**

Lynn Borgatta 34299

Print name of physician **(printed name and license number must be legible to process this form)** **License #**

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee and 3) the Physician Survey (optional) in the enclosed return envelope Direct questions to (303) 894-7690 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver CO 80202-5140

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
Susan Miller
Program Administrator

1560 Broadway, Suite 1300
Denver, CO 80202-5140
(303) 894-7690

Department of Regulatory Agencies
Joseph A. Garcia
Executive Director

Division of Registrations
Bruce M. Douglas, Director

Roy Romer
Governor

May 23, 1995

Lynn Borgatta, M.D.
175 Tarrytown Road
White Plains, New York 10607

Dear Doctor Borgatta:

At a meeting of the Colorado Board of Medical Examiners held on May 18, 1995, your application for Colorado medical licensure was approved.

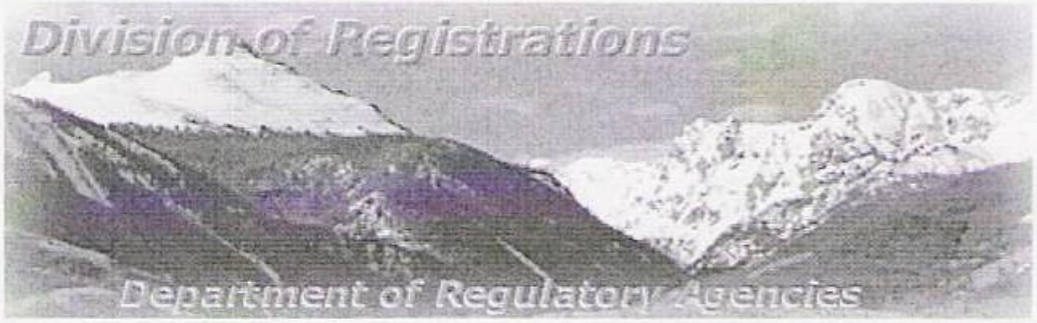
Your license number is # 34299 effective May 18, 1995.

All physician licenses expire during May of each odd numbered year, and once renewed are good for a two year period. Your license will expire May 31, 1997 - please note this date. Notice of the renewal fee will be sent to you at the last address of record in our files. It is important to inform the Board of any changes in work or home address in order to ensure that your renewal packet will reach you in a timely manner. A second renewal notice is not required by law. It is the responsbility of each physician to remit the registration fee to this office, even though the original notice fails to reach the physician. The Board cannot assume responsibility for changes of address that do not reach this office.

Sincerely,

FOR THE BOARD OF MEDICAL EXAMINERS

Jan Seewald
Administrative Assistant



Individual Information
All Licensing Types

Back to your search results
New Search

Lynn Borgatta

Address	%DEPT OF OB/GYN BOSTON MEDICAL CTR 91 E CONCORD ST MAT 3 BOSTON, MA 02118
Phone Number	(617) 414-5593
License Number	DR-34299
License Type	Physician
License Status	Lapsed
License Method	National Licensing Board
License First Issued	May 18, 1995
Last Renewal Date	June 01, 2003
Last Expiration Date	May 31, 2005
Board or Program actions	No actions on file (Information about Program or Board Actions)

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E-Mail the **Division of Registrations**
1560 Broadway, Suite 1350
Denver, CO 80202
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