Dora
Department of Regulatory Agencies

Division of Registrations
Rosemary McCool
Director

Colorado Medical Board
Marschall S. Smith
Program Director

Bill Ritter, Jr.
Governor

Barbara J. Kelly
Executive
Director

November 17, 2010

G. Gupto
Post Office Box 51213
Boston, Massachusetts 02205

RE: Lori Lynn Holst Thorndike, M.D.
License Numbers: DR-44567 and TL-1317

Dear Mr. Gupto:

This letter is in response to your email request for Colorado Open Records Act ("CORA") information about the above mentioned physician. The Colorado Medical Board ("Board") records have been reviewed to determine which materials may be responsive to your request.

1. Medical Malpractice information. The Board has not been made aware of any malpractice claims. This information can be verified from our website at www.dora.state.co.us/medical and click on the "ALISON" link at the bottom of the page.
2. Complaints and disciplinary actions. Dr. Thorndike has had no Board actions taken against her license. You may verify this statement by visiting our website at www.dora.state.co.us/medical and click on the "ALISON" link at the bottom of the page. Information that is Attorney-Client Privileged and the Board's investigatory files, which are protected under 24-72-204(2)(a)(I) C.R.S. and 12-36-118(10), C.R.S., were excluded from this request.
3. Applications. Dr. Thorndike's application for her physician training license and her medical license are attached. Non-public information has been redacted from the information provided. Information that is Attorney-Client Privileged, which are protected under 24-72-204(2)(a)(I) C.R.S. were excluded from this request.
4. Hospital Information. The Board is aware of two Colorado hospitals where Dr. Thorndike has an affiliation. Those hospitals are: North Suburban Medical Center in Thornton, Colorado and Saint Anthony North Hospital in Westminster, Colorado. You may verify this statement by visiting our website at www.dora.state.co.us/medical and clicking on the link to physician profiles in the left hand side of the page then following the instructions to access Dr. Thorndike's information.

Should you have any questions regarding this information, please do not hesitate to contact me.

Sincerely,

FOR THE COLORADO MEDICAL BOARD

Marschall S. Smith
Program Director

Enclosure

COLORADO STATE BOARD OF MEDICAL EXAMINERS

APPLICATION FOR A PHYSICIAN TRAINING LICENSE **FEE $20.00**

READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS APPLICATION. ALL QUESTIONS 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 IF NECESSARY.**

1 a. Name: Last	First	Middle	Degree	1b. Social Security Number
aka Thorndike Holst	Lori	Lynn	D.O.	

2. Other names (i.e. maiden name)- indicate if none.
no maiden name

3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE, Address provided is, by law, public information.)
☐ Home
☒ Business 2005 Franklin, Midtown II, #200, CO 80205 USA

City: Denver | State | Zip | Country

e-mail address:

4. Telephone Number: (Area Code) (Day) Evening: 303-318-2015

5. Date of Birth: Mo/Day/Year

6. Sex: Male / (Female)

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

8. List name/address of the school where medical degree was received.

Name of School	City and State	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Univ. of New England	Biddeford, ME	7/00	6/04

9. List the name and address of the Colorado training program into which you have been accepted.
Name St. Joes
Address 2005 Franklin Midtown II #200 CO 80205

10. Have you received and/or completed postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs?
☐ Yes If yes, provide information below.
☒ No

Name of facility	Specialty	Period of attendance From (Mo/Yr)	Period of attendance To (Mo/Yr)

11. 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.
☐ Yes If yes, provide information below.
☒ No

State or country	License #	Dates of Practice in this jurisdiction Issue Date	Dates of Practice in this jurisdiction Expiration Date

12. 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?**
[redacted] give details below.

State	Date	Charge	Disposition
[redacted]			

13. 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.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question.
[redacted]

State	Date	Charge	Disposition
[redacted]			

MAY 13 2004

Official Use Only	License # 17717	Date
Revised 10/99	Fee $	Date:

RECEIVED
MAY 11 2004
DIVISION OF REGISTRATIONS

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, Lori Lynn Holst 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 in this application is true and correct to the best of my knowledge. I further state that I have read all disclosures contained in the application packet including the one related to social security numbers.

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.

I understand that this license will only be valid for the training program listed below, and should I enter another program, that I will need to re-apply.

I understand that this license will only be valid for the training program listed below, and should I wish to practice medicine in Colorado outside the training environment, I would need to apply for a license to practice medicine in the State of Colorado.

I further understand that the issuance of this training license is not a guarantee of issuance of a license to practice medicine in the State of Colorado.

Lori Lynn Holst
Signature

03/22/04
Date

This section to be completed by Program Director, Clinical Director or by Training Supervisor
(NOTE: If separate statement has already been submitted to the Board, this section does not need to be completed. Please check with your training program to see if this information has been submitted to the Medical Board.)

Name of Training Program Exempla Saint Joseph Hospital Family Practice

Location of Training Program 2005 Franklin, Midtown II, #200, Denver, CO 80205

I certify that this applicant meets the criteria set forth in 12-36-122 (2) C.R.S., and that the training program indicated above, will accept responsibility for the applicant's medical training, while in the program.

Signature of Program Director, Clinical Director or Supervising Physician

4/22/04
Date

RETURN THIS APPLICATION AND FEE TO:

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

T1C

COLORADO STATE BOARD OF MEDICAL EXAMINERS

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE **FEE $425.00**

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 SURFICIENT COPIES OF ALL FORMS BEFORE YOU BEGIN.**

1 a. Name: Last	First	Middle	Degree	1b. Social Security Number
Thorndike	Lori	Lynn Holst	D.O.	

2. Other names (i.e. maiden name)- indicate if none.	What is your speciality(s)
Lori Lynn Holst	Family Medicine

3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE, Address provided is, by law, public information)

☒ Home
☐ Business 2520 Gaylord Street

City	State	Zip	Country
Denver	CO	80205	USA

e-mail address:

4. Telephone Number: (Area Code) Day Evening	5. Date of Birth: Mo/Day/Year	Place of Birth
303 321-1414 (h) 303 518-2938 (c)		Pittsburgh, PA

6. Sex: Male (Female)

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

8.a. 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	Address and Zip	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Univ. of New England COM	11 Hills Beach Rd. Biddeford ME 04005	6/00	6/04

8 b. If this is an international medical school, please provide the country where the school is physically located:

9. 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
[redacted]	

10. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs?
☒ Yes If Yes, provide information below.
☐ No

Name of facility	Specialty	Period of attendance From (Mo/Yr)	Period of attendance To (Mo/Yr)
Exempla St Joseph's Hospital	Family Medicine	6/04	Present

11. Are you Board Certified by either the American Board of Medical Specialties or the American Osteopathic Association?
☐ Yes If Yes, list certification information.
☒ No

L1A

Official Use Only	License # 44507 RECEIVED	Date 4/26/06
Revised 10/99	Fee $	Date:

JAN 30 2006 JB

DIVISION OF REGISTRATIONS

4/25/06 MJ

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.

☒ Yes If Yes, provide information below.

☒ No

State or country	License #	Dates of Practice in this jurisdiction	
		Issue Date	Expiration Date
Colorado	1317	4/04	8/31/07

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?**

[redacted]e details below and request official complaint and/or investigative report be sent directly to the Board from the licensing body, as [redacted]ly submit a narrative regarding the complaint.

State	Date	Charge	Disposition
[redacted]			

14. Has any healing arts license which you now hold or have ever held been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any healthcare facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question.

[redacted]es, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent [redacted]the Board, as well as a narrative regarding the action taken.

State	Date	Charge	Disposition
[redacted]			

15. Have you ever entered into any agreement with any state, territory, district, country, US government agency, and state medical/osteopathic board regarding your medical license?

[redacted]Yes, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent [redacted]the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason
[redacted]		

16. 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 US federal jurisdiction?

[redacted]Yes, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or [redacted]ds be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason for denial
[redacted]		

17. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in any state country or U.S. federal jurisdiction? This does not include allowing your license to lapse solely due to non-payment of the renewal fee.

[redacted]summarize below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or [redacted]nds be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason
[redacted]		

L1B

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, Lori Lynn Holt Thorndike 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.

I understand that if my application does not have any issues which require Board review my application will be administratively approved as soon as it becomes complete unless I indicate otherwise below.

☐ Process my application for review now.
☒ Process my application for review on or after (list month and year): 2/06

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 further state that I have read all disclosures contained in the application packet including the one related to social security numbers.

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.

Holt Thorndike — Signature

11/19/05 — Date

RETURN THIS APPLICATION TO:

COLORADO BOARD OF MEDICAL EXAMINERS
1560 BROADWAY, SUITE 1350
DENVER CO 80202-5140

L1D

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS **Department of Regulatory Agencies**
1560 Broadway, Suite 1350
Denver, Colorado 80202-5146
Phone (303) 894-7800
Fax (303) 894-7693
V/TDD (303) 894-7880
www.dora.state.co.us/medical

Division of Registrations

REPORT OF PRACTICE HISTORY

Facility Name	Address and Zip	Reference (name and title)	Dates of Practice From-To	Nature of Practice
1. Exempla St. Joseph's Hospital	2005 Franklin Street Midtown II Suite 200 Denver, CO 80205	Laurel Allen - Program Coord.	6/04 - 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 18-8-503, 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.

SIGNATURE [signature] Thorndike PRINT LAST NAME 11/19/05 DATE

L6

NOV 28 2005

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1350
Denver, Colorado 80202-5146
Phone (303) 894-7800
Fax (303) 894-7693
V/TDD (303) 894-7880
www.dora.state.co.us/medical

Department of Regulatory Agencies
Division of Registrations

RECEIVED
NOV 30 2005
DIVISION OF REGISTRATIONS
JB

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies
that Lori Lynn Holst Thorndike
FULL NAME OF APPLICANT

enrolled in
University of New England College of Osteopathic Medicine
FULL NAME OF MEDICAL SCHOOL

Biddeford, ME on the 2 day of August
~~2000~~
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 2ND day of August, 2000 and was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 5TH day of June, 2004.

Signed and the college seal affixed

This 28TH day of November, 2005

By Kevin M. Stanley University Registrar

NOT VALID WITHOUT SCHOOL SEAL
NOTE TO REGISTRAR:
IF NO SCHOOL SEAL, PLEASE INDICATE ABOVE, NEXT TO SIGNATURE OF PRESIDENT/SECRETARY/DEAN.

L2