LM

KANSAS STATE BOARD OF HEALING ARTS

RECEIVED

APPLICATION FOR REINSTATEMENT

1990 APR 11 PM 12:54

☐ MEDICINE AND SURGERY ☐ CHIROPRACTIC ☒ OSTEOPATHIC MEDICINE AND SURGERY

KANSAS BOARD OF HEALING ARTS

PRINT OR TYPE ANSWERS TO ALL QUESTIONS ON THIS FORM IN FULL

I. GENERAL INFORMATION

1. NAME: LESLIE (FIRST) ELLEN (MIDDLE) Fox (MAIDEN) PAGE (LAST)
2. NAME AS YOU WISH IT TO APPEAR ON YOUR LICENSE: LESLIE E.F. PAGE
3. MAILING ADDRESS: P.O. Box 6576 Springfield, IL 62708-6576 PHONE: ———
4. CURRENT PLACE OF RESIDENCE Confidential Springfield IL 62704 PHONE: Confidential
5. CURRENT PLACE OF PRACTICE: Residency - S.I.U. OB-GYN PHONE: (217) 782-8247
6. DATE OF BIRTH: Confidential 52 7. S.S. NO. Confidential
8. PLACE OF BIRTH: ARLINGTON (CITY) VA (STATE) U.S.A (COUNTRY)

9. AS A RESULT OF THIS APPLICATION DO YOU INTEND TO CHANGE THE LOCATION OF YOUR PRACTICE? ☒ YES ☐ NO
If yes, give location and date of intended establishment of practice:
Location: FORT SCOTT, KS Date: 7-1-91

10. PRIMARY SPECIALTY: OBSTETRICS & GYNECOLOGY ☐ AMERICAN BOARD CERTIFIED ☒ AMERICAN BOARD ELIGIBLE

11. SECONDARY SPECIALTY: (general practice) ☒ OSTEOPATHIC AMERICAN BOARD CERTIFIED ☐ AMERICAN BOARD ELIGIBLE

USE ADDITIONAL PAGES IF NECESSARY.

II. PROFESSIONAL ACTIVITIES

LIST IN CHRONOLOGICAL ORDER ALL PROFESSIONAL ACTIVITIES SINCE GRADUATION, INCLUDING INTERNSHIPS, HOSPITAL AFFILIATIONS AND ABSENCES FROM WORK. ALSO LIST ALL PERIODS OF NON-PROFESSIONAL ACTIVITY OR EMPLOYMENT FOR MORE THAN THREE MONTHS. PLEASE ACCOUNT FOR ALL TIME. IF ENGAGED IN PRIVATE PRACTICE, LIST HOSPITAL AFFILIATIONS. IF NONE, PLEASE EXPLAIN. USE ADDITIONAL PAGES IF NECESSARY.

FROM MO YR	TO MO YR	LOCATION AND COMPLETE ADDRESS	POSITION HELD
7-1-82	7-1-83	Riverside Hosp. 3632 W. Central Ave Wichita KS	INTERN
7-1-83	6-28-87	1940 N. West St, Wichita KS 67203	PRIVATE PRACTICE **
7-1-87	current	Southern Illinois University, Dept OB-GYN	RESIDENT **
		800 N. Rutledge, D-226, Springfield IL 62708	
		* St Francis Regional Medical Ctr	active staff
		* Riverside Hospital	
		* * Memorial Hospital	courtesy staff
		* * St John's Hospital	

EXPLANATION:

III. POSTGRADUATE EDUCATION

POST GRADUATE: ROTATING INTERNSHIP RIVERSIDE HOSPITAL	HOSPITAL:
CITY: Wichita STATE OR COUNTRY: KS	CITY: STATE OR COUNTRY:
MO YR ENTERED: 7/82 MO YR GRADUATED: 6/83	MO YR ENTERED: / MO YR GRADUATED:
SPECIALTY: general (osteopathic) medicine	SPECIALTY:
HOSPITAL: Southern Illinois University affiliated hospitals	HOSPITAL:
CITY: Springfield STATE OR COUNTRY: IL	CITY: STATE OR COUNTRY:
MO YR ENTERED: 7/87 MO YR GRADUATED: 6/91	MO YR ENTERED: / MO YR GRADUATED: /
SPECIALTY: Obstetrics & Gynecology	SPECIALTY:
HOSPITAL:	HOSPITAL:
CITY: STATE OR COUNTRY:	CITY: STATE OR COUNTRY:
MO YR ENTERED: / MO YR GRADUATED: /	MO YR ENTERED: / MO YR GRADUATED: /
SPECIALTY:	SPECIALTY:

EXPLANATION:

IV. PREVIOUS LICENSURE

LIST ALL STATES IN WHICH YOU HAVE BEEN LICENSED OR ARE CURRENTLY LICENSED. MAKE NO OMISSIONS CONCERNING PREVIOUS LICENSURE OR ANY DISCIPLINARY ACTION.

STATE/COUNTRY	LICENSE NO.	DATE	HOW OBTAINED (Exam., Recip., Nat'l Bd., FLEX)	DISCIPLINARY ACTIONS	CURRENT (Circle)
KANSAS	20200	9/1/83	Nat'l Boards	NONE	YES (NO)
ILLINOIS		11/1/84	Reciprocal	NONE	(YES) NO
					YES NO
					YES NO
					YES NO
					YES NO

EXPLANATION OR COMMENTS: _____

V. PROFESSIONAL LIABILITY INSURANCE (MALPRACTICE)

If you are rendering professional services in Kansas, you are required by K.S.A. 40-3401-3419 to maintain professional liability insurance of not less than $200,000 per occurrence (per claim) subject to not less than $600,000 annual aggregate for all claims made during the policy period and to participate in the Kansas Health Care Stabilization Fund.

1. In what company do you carry professional Liability Insurance? NOT APPLICABLE UNTIL 7/1/91

2. Have any malpractice suits, claims or settlements been made against you? If so, how many and provide a letter from your attorney explaining each case. ☐ YES ☒ NO

VI. STATEMENT OF HEALTH

Do you presently have any physical or mental problems or disabilities which could effect your ability to competently practice your particular branch of the healing arts or your particular specialty?

Confidential

If yes, applicant shall file with this application, a detailed statement of his/her health, diagnosis and prognosis, supported by report of his/her attending physician including any medication and treatment currently being prescribed.

VII. RECOMMENDATIONS FROM TWO REPUTABLE PHYSICIANS

1. This is to certify that I have known Dr. Leslie F. Page of Springfield, IL whose photograph is hereto attached, for 3 years; that he/she is a capable physician and is not addicted to alcohol or narcotics.

I further certify that to the best of my knowledge and belief Dr. Page is a fit and proper person for reinstatement of license by the Kansas State Board of Healing Arts.

Signed Robert D Hilgers

Robert D. Hilgers, M.D.
Print or Type Name

Address Dept. of OB/GYN, SIU School of Medicine
State Box 19230, Springfield, IL 62794-9230
Phone 217/782-8247

2. This is to certify that I have known Dr. (See attached) Leslie Page of Springfield, Ill whose photograph is hereto attached, for 3 years; that he/she is a capable physician and is not addicted to alcohol or narcotics.

I further certify that to the best of my knowledge and belief Dr. Leslie Page md is a fit and proper person for reinstatement of license by the Kansas State Board of Healing Arts.

Signed Robert D Hilgers

Robert D Hilgers md
Print or Type Name

Address SIU School of Medicine
State Springfield, Ill 62708
Phone 217-782-8247

VIII. DISCIPLINE

WE ROUTINELY RECEIVE INFORMATION FROM VARIOUS STATES, FEDERAL AND PRIVATE AGENCIES AND ASSOCIATIONS ABOUT ACTION TAKEN AGAINST LICENSEES OR PRACTITIONERS. ALL INFORMATION RECEIVED WILL BE CHECKED ACCORDINGLY TO VERIFY THE TRUTH AND VERACITY OF YOUR ANSWERS. IN OTHER WORDS, IF THE QUESTION IS IN ANY WAY APPLICABLE, ANSWER YES AND THEN EXPLAIN IN THE SPACE PROVIDED.

1. Have you ever been rejected for membership or notified by or requested to appear before any medical, osteopathic or chiropractic society?
   YES (NO) (Circle one)
2. Have you ever been denied the privilege of taking an examination administered by a licensing agency?
   YES (NO) (Circle one)
3. Have you ever been denied a license to practice the healing arts or other health care profession?
   YES (NO) (Circle one)
4. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other hospital care facility?
   YES (NO) (Circle one)
5. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended, been put on probation, or ever been requested to withdraw from any licensed hospital, nursing home, clinic or other hospital care facility in which you have trained, been a staff member, been a partner or held hospital privileges?
   Confidential
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation, or other practice organization, either public or private?
   YES (NO) (Circle one)
7. Have you ever, for any reason, lost American Board certification?
   YES (NO) (Circle one)
8. Has any licensing or disciplinary agency limited, restricted, suspended or revoked a license you have held?
   YES (NO) (Circle one)
9. Have you ever voluntarily surrendered a license issued to you by a licensing or disciplinary agency?
   YES (NO) (Circle one)
10. Have you ever been notified or requested to appear before any licensing or disciplinary agency?
    YES (NO) (Circle one)
11. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?
    YES (NO) (Circle one)
12. Have you ever been addicted to, dependent upon or impaired by alcohol, narcotics, barbiturates, or other drugs affecting the central nervous system, or other drugs which may cause physical or psychological dependence?
    Confidential
13. Have you ever been a patient (voluntarily or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or alcohol problems?
    Confidential
14. Have you ever been treated, but not hospitalized, for emotional or mental illness, drug addiction or alcohol problems?
    Confidential
15. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics controlled substances registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?
    YES (NO) (Circle one)
16. Have you ever surrendered your state or federal controlled substances registration or had it restricted in any way?
    YES (NO) (Circle one)
17. Have you ever been arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation?
    YES (NO) (Circle one)
18. Have you ever been a defendant in a legal action involving professional liability (Malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?
    YES (NO) (Circle one)
19. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs?
    YES (NO) (Circle one)
20. Have you ever terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicare Programs?
    YES (NO) (Circle one)

BLANK SPACE IS PROVIDED FOR YOUR USE IN ANSWERING THE ABOVE QUESTIONS. IF MORE SPACE IS NEEDED, USE ADDITIONAL PAGE.

IX. AFFIDAVIT

I, Leslie F. Page, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery, osteopathic medicine and surgery or chiropractic in the state of Kansas and may subject me to a fine not exceeding $10,000 and term of imprisonment not exceeding 5 years for each violation. (K.S.A. 21-3805)

Leslie F. Page, DO

Signature of Applicant

This Filing to be Filled Out by the Secretary Only

REINSTATEMENT

The Kansas State Board of Healing Arts

OFFICE RECORD—(Leave blank)

Name Leslie Fay Page DO

Address 1047 North Waco

City Wichita

State KS 67203

Certificate No. 4-20200

Reinstatement Approved:

[illegible]

Secretary

X. RELEASE

STATE OF Illinois

COUNTY OF Sangamon

THE APPLICANT Leslie F. Page

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Kansas State Board of Healing Arts or its successors any information, files or records requested by that board in connection with this application. I further authorize the Kansas State Board of Healing Arts or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

Leslie F. Page DO
Applicant's Signature

Subscribed and sworn to before me this 9th day of April, 1990

Doris L. Coe
Notary Public

My appointment expires on the [illegible] 23rd day of Sept, 1992

OFFICIAL SEAL
DORIS L. COE
Notary Public - Sangamon County
State of Illinois
My Commission Expires September 23, 1992

XI. ATTACH PHOTOGRAPH HERE

1.
2.
3.
4.
5.

Illinois Department of Professional Regulation

Kevin K. Wright
Director

James R. Thompson
Governor

RECEIVED
JUN 25 1990
KANSAS STATE BOARD OF HEALING ARTS

C E R T I F I C A T I O N

June 21, 1990

Kansas State Board of Healing Arts
235 South Topeka Boulevard
Topeka, KS 66603-3059

I, Kevin K. Wright, do hereby certify that I am the Director of the Department of Professional Regulation, a department of the government of the State of Illinois; that I am the keeper of the records of the Department of Professional Regulation and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	LESLIE F. PAGE
WAS ISSUED LICENSE NO:	036-75328
ON:	JULY 2, 1987
TO PRACTICE AS A:	LICENSED PHYSICIAN AND SURGEON
LICENSED BY:	ACCEPTANCE OF NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS
CURRENT LICENSURE STATUS IS:	ACTIVE
CURRENT LICENSE EXPIRES:	JULY 31, 1993

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED.

The information above is the only certification information provided by this Department. If other information is needed, it must be obtained from the above-named individual or the agency or institution which initially generated the information. To expedite the certification process, the above format is the standard format prepared for all professions regulated by this Department.

For detailed information regarding the type and length of discipline, if any, submit a written request to the Regulatory Unit at the Department's Chicago office.

Kevin K. Wright
Director

S E A L

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800

State of Illinois Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/814-4500