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 SUFFICIENT COPIES OF ALL FORMS BEFORE YOU BEGIN.**

1 a. Name: Last: DIXON First: ANNE Middle: B Degree: MD

1b. Social Security Number:

2. Other names (i.e. maiden name)- indicate if none.

What is your speciality(s): OB/GYN

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

☒ Home
☐ Business 1100 Downing St Apt #1

City: Denver State: CO Zip: 80218 Country: USA

e-mail address:

4. Telephone Number: (Area Code) Day: 303 331 8634 Evening:

5. Date of Birth: Mo/Day/Year Place of Birth: Frankfurt, Germany

6. Sex: Male (Female) — Female circled

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)	To (Mo/Yr)
Univ of Connecticut	263 Farmington Ave Farmington, CT 06030	8/97	6/01

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	Date	Result
USMLE Step 1	Connecticut	6/14/99	
USMLE Step 2	Connecticut	9/28/00	
USMLE Step 3	Colorado	5/12/03	

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)	To (Mo/Yr)
University of Colorado	OB/GYN	6/01	Present (ends 6/05)

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 # 43613	Date 5/19/05
Revised 10/99	Fee $	Date

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.

CK#1314 3/17/05 425.00 R246

☒ Yes If Yes, provide information below.
☐ No

State or country	License #	Dates of Practice in this jurisdiction	
		Issue Date	Expiration Date
Colorado (Training license)	254	8/7/02	8/31/05

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?**

☐ **Yes** If Yes, give details below and request official complaint and/or investigative report be sent directly to the Board from the licensing body, as well as personally submit a narrative regarding the complaint.
(No) — circled

State	Date	Charge	Disposition

14. 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.

☐ **Yes.** If Yes, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board, as well as a narrative regarding the action taken.
☒ No

State	Date	Charge	Disposition

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?

☐ **Yes** If Yes, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.
☒ No

Agency	Date	Reason

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?

☐ **Yes** If Yes, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.
☒ No

Agency	Date	Reason for denial

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.

☐ **Yes** If Yes, summarize below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.
☒ No

Agency	Date	Reason

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

☐ Yes If Yes, summarize below AND request hospital to submit a report directly to the Board regarding the suspensions etc. Also submit your narrative regarding the suspension of privileges.

☒ No

Name of facility	Date	Reason for action

19. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law? Note: You must respond "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.

☐ Yes If Yes, summarize below AND submit your narrative regarding the incident as well as court and police records and information regarding final disposition of the case.

☒ No

Date	Court	Violation	Penalty or disposition

20. Within the last five years, have you engaged in any behavior or suffered any mental, physical or cognitive health condition that has affected or might affect your ability to practice medicine safely and competently? You may answer NO if the behavior or condition is already known to the Colorado Physician Health Program ("CPHP"). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

☐ Yes If Yes, submit an explanation to the Board regarding the behavior or condition. Be specific as to date of occurrences, the type of behavior or condition involved, and what if anything has been done to correct the behavior or condition. Any discharge summaries, evaluations, or reports must be submitted directly to the Board from the source.

☒ No

21. Within the last five years, have you illegally or excessively used any controlled substance, habit-forming drug, prescription medication, or alcohol? You may answer NO if your use of such substances is already known to the Colorado Physician Health Program ("CPHP"). "Known to CPHP" means that you have informed CPHP of your use of such substances and you are complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

☐ Yes If Yes, submit to the Board, an explanation regarding the offense/situation. Be specific as to date of occurrences, the type of behavior involved, and what if anything has been done to correct the behavior. Must also submit copies of the DUI or DWAI court records and police reports.

☒ No

22. Within the last five years,

- have you been diagnosed or treated for bipolar disorder, severe major depression, schizophrenia or other psychotic disorder?
- Have you been diagnosed with or treated for a neurological illness or sleep disorder that disturbs your cognition, behavior or motor function?
- Have you undergone a cardiac bypass procedure?

You may answer NO if the behavior or condition is already known to the Colorado Physician Health Program ("CPHP"). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

☐ Yes If Yes, submit explanation to the Board regarding the diagnosis or disorder(s). Be specific as to date of occurrences, the type of disorder involved, and what if anything has been done to treat the disorder. Any discharge summaries, evaluations, or reports must be submitted directly to the Board from the source.

☒ No

23. Within the last five years, has any final judgment, settlement or arbitration award for medical malpractice been paid on your behalf or has any claim been filed which is still pending?

☐ Yes If Yes, summarize below AND submit to the Board a completed malpractice claims form and a clinical narrative regarding your involvement in the case.

☒ No

Date	Name and address of Insurance Company	Reason for Action

24. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been canceled or rated at a higher premium due to past claims experience?

☐ Yes. If Yes, submit to the Board an explanation regarding the cancellation or increase in premiums of the insurance and verification directly from the insurance company to the Board.

☒ No

25. You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado Law, or claim one of the four exemptions set forth in the enclosed insurance memo. See instructions in application packet, and include proof of insurance (obtained from your insurance carrier) or include a statement setting forth the basis for the exemption claimed below.

EXEMPTION CLAIMED: ____

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, Anne B. Dixon 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):__________

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.

Anne Dixon (signature) — Signature

3.6.05 — Date

RETURN THIS APPLICATION TO:

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

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.	University of Colorado Health Sciences Center	4200 E. 9th Ave Denver, CO 80262	Ronald Gibbs, MD Chairman Kirsten Lund, MD Program Director	6/01 – 6/05	Resident Training
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: Anne Dixon   PRINT LAST NAME: DIXON   DATE: 3.6.05   L6

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

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Anne B. Dixon
FULL NAME OF APPLICANT

enrolled in University of Connecticut
FULL NAME OF MEDICAL SCHOOL

Farmington, CT on the 15th day of August 19 97
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 11th day of August, 1997 and was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 24th day of May, 2001.

Signed and the college seal affixed

This 29th day of March, 2005

By Linda Greene, Asst Registrar

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

L2

University of Colorado Health Sciences Center

School of Medicine
Office of Graduate Medical Education

4200 East Ninth Avenue, C293, Denver, Colorado 80262
Phone: 303 315-7424, Fax: 303 315-7399

CONFIRMATION OF MALPRACTICE COVERAGE

Date: March 21, 2005
*Resident: Anne Dixon
Program begin date: June 23, 2001
Program end date: Expected to complete June 30, 2005

The University of Colorado Health Sciences Center provides medical malpractice coverage for its employees, residents, students, and volunteers through a combination of self-insurance and commercial insurance. This coverage is subject to the terms of the University of Colorado Self-Insurance and Risk Management Trust Coverage Document. Coverage extends to injuries arising from acts or omissions occurring during the performance of the covered person's duties and within the scope of the covered person's duties and within the scope of the covered person's employment or training, unless the act or omission was willful and wanton.

The Trust's coverage extends to employees, residents, students, and volunteers defined in the Trust Coverage Document and in accordance with the Colorado Governmental Immunity Act (C. R. S. 24-10-101 et. seq.). These employees, residents, students, and volunteers are considered to be
"public employees" under the Colorado Governmental Immunity Act and their liability is limited by the Act as follows:

(a) for any injury to one person in any single occurrence, the sum of $150,000;
(b) for any injury to two or more persons in any single occurrence, the sum of $600,000; except in such instance, no person may recover in excess of $150,000.

For claims subject to the protection of the Colorado Governmental Immunity Act, if a court of competent jurisdiction rules as a final judgment that the limitations of the Act are not applicable to the University, the University of Colorado Hospital, a particular public employee, faculty member or student, then the Trust provides **secondary** coverage through a commercial policy which has limits of at least $1,000,000 per occurrence and $3,000,000 in aggregate. Both the coverage under the Colorado Governmental Immunity Act as well as the secondary coverage provided be the Trust which are outlined above apply to acts that occurred within the course and scope of the employees work for the university or which occurred during the time that the resident or student was enrolled in the program.

All inquiries regarding the coverage provided or claims history for the individual named below should be directed to the Office of Professional Risk Management, PO Box 6508, Mail Stop F- 407, Aurora, CO 80045.

Carol M. Rumack, M.D./Designee
Associate Dean
Graduate Medical Education

* ACGME defines "resident" as intern, resident, and fellow.