

**COLORADO BOARD OF MEDICAL EXAMINERS
2001 LICENSE RENEWAL QUESTIONNAIRE**

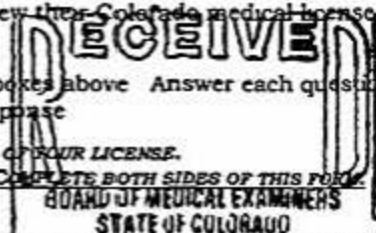
LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #	LICENSE #
BOCK	PAMELA	A	1	36747

PLEASE PRINT LEGIBLY. KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

NOTE: The Colorado Medical Practice Act mandates that all licensed physicians wishing to renew their Colorado medical licenses must complete this questionnaire and renewal application

INSTRUCTIONS: Print or type your name, social security number and license number in the boxes above. Answer each question below, and provide the information and documentation requested for each "yes" response.

*RESPONDING "YES" TO ANY OF THESE QUESTIONS WILL NOT DELAY RENEWAL OF YOUR LICENSE.
AN INCOMPLETE OR INACCURATE FORM, HOWEVER, WILL RESULT IN DELAY OF YOUR RENEWAL. COMPLETE BOTH SIDES OF THIS FORM.*



A) Since you last renewed your Colorado medical license, have you

- 1 had any adverse action taken against you by any licensing agency in another state or country, any peer review body, health care facility, professional or medical society or association, governmental agency, law enforcement agency, or court of law?

If "YES", provide a detailed summary of the events, which led to the adverse action. Include the name and address of the entity that took the action, the date of the action, correspondence from the entity regarding the matter, and whether action is still pending.

- 2 surrendered a license or other authorization to practice medicine in another state or jurisdiction, or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?

If "YES", provide a detailed summary of the events, which led to the adverse action. Include the name and address of the entity that took the action, the date of the action, correspondence from the entity regarding the matter, and whether action is still pending.

- 3 had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? **NOTE:** Include any payments you have made personally.

If "YES", provide a detailed clinical summary of your care and treatment of the patient. Include the name of the patient, the amount and date of settlement, and a current copy of your complete National Practitioner Data Bank report. (The Board may request patient records in the matter at a later date.)

- 4 been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier?

If "YES", provide a copy of the notification from the insurance carrier and a summary of the events, which led to the denial. If you do not have a copy of the notification, contact the insurance carrier to obtain one.

- 5 had any felony or misdemeanor charges of any kind brought against you? Had any traffic citations involving drugs or alcohol, brought against you? Regardless of the case disposition, you must answer yes if you have been charged.

If "YES", provide a detailed summary of the events, which led to the charges or citation. Include with your summary a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.

- 6 illegally or excessively used any controlled substance, habit-forming drug, prescription medication, or alcohol? You may answer "NO" if the behavior is already known to the Colorado Physician Health Program (CPHP).

If "YES", provide a detailed summary of the condition or event. Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers.

- 7 engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine with skill and safety to patients? You may answer "NO" if the behavior is already known to the Colorado Physician Health Program (CPHP).

If "YES", provide a detailed summary of the condition or event. Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers.

B) Since you last renewed your Colorado medical license, have either of the following been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "YES" to the items below if any of these actions are currently pending. **NOTE:** You must answer "YES" if you have withdrawn or failed to proceed with an application for any of these items.

- 1 Medical staff membership or clinical privileges at any hospital or healthcare facility?

If "YES", provide a detailed summary of the conduct/allegations upon which action was taken. Include the notification to you from the hospital(s) or facility(s). If you do not have the notification(s), contact the hospital(s) or facility(s) to obtain one.

- 2 DEA registration?

If "YES", provide a detailed summary of the conduct/allegation upon which action was taken. Include the notification from DEA. If you do not have a copy of the notification, contact DEA to obtain a copy.

HAVE YOU PREVIOUSLY REPORTED ANY OF THE ABOVE MATTERS TO THE BOARD?

IF YES, PROVIDE DOCUMENTATION IN SUPPORT OF YOUR RESPONSE. IF APPLICABLE, PROVIDE A COPY OF THE FINAL DISPOSITION FROM THE BOARD.

**COLORADO BOARD OF MEDICAL EXAMINERS
2001 LICENSE RENEWAL QUESTIONNAIRE**

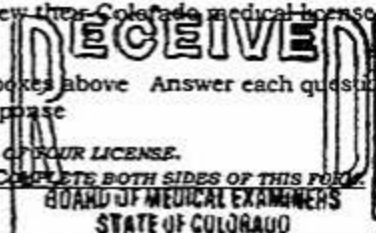
LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #	LICENSE #
BOCK	PAMELA	A	457-19-0206	36747

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NOTE: The Colorado Medical Practice Act mandates that all licensed physicians wishing to renew their Colorado medical licenses must complete this questionnaire and renewal application

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- 1 had any adverse action taken against you by any licensing agency in another state or country, any peer review body, health care facility, professional or medical society or association, governmental agency, law enforcement agency, or court of law?

If "YES", provide a detailed summary of the events, which led to the adverse action. Include the name and address of the entity that took the action, the date of the action, correspondence from the entity regarding the matter, and whether action is still pending.

- 2 surrendered a license or other authorization to practice medicine in another state or jurisdiction, or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?

If "YES", provide a detailed summary of the events, which led to the adverse action. Include the name and address of the entity that took the action, the date of the action, correspondence from the entity regarding the matter, and whether action is still pending.

- 3 had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? **NOTE:** Include any payments you have made personally.

If "YES", provide a detailed clinical summary of your care and treatment of the patient. Include the name of the patient, the amount and date of settlement, and a current copy of your complete National Practitioner Data Bank report. (The Board may request patient records in the matter at a later date.)

- 4 been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier?

If "YES", provide a copy of the notification from the insurance carrier and a summary of the events, which led to the denial. If you do not have a copy of the notification, contact the insurance carrier to obtain one.

- 5 had any felony or misdemeanor charges of any kind brought against you? Had any traffic citations involving drugs or alcohol, brought against you? Regardless of the case disposition, you must answer yes if you have been charged.

If "YES", provide a detailed summary of the events, which led to the charges or citation. Include with your summary a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.

- 6 illegally or excessively used any controlled substance, habit-forming drug, prescription medication, or alcohol? You may answer "NO" if the behavior is already known to the Colorado Physician Health Program (CPHP).

If "YES", provide a detailed summary of the condition or event. Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers.

- 7 engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine with skill and safety to patients? You may answer "NO" if the behavior is already known to the Colorado Physician Health Program (CPHP).

If "YES", provide a detailed summary of the condition or event. Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers.

B) Since you last renewed your Colorado medical license, have either of the following been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "YES" to the items below if any of these actions are currently pending. **NOTE:** You must answer "YES" if you have withdrawn or failed to proceed with an application for any of these items.

- 1 Medical staff membership or clinical privileges at any hospital or healthcare facility?

If "YES", provide a detailed summary of the conduct/allegations upon which action was taken. Include the notification to you from the hospital(s) or facility(s). If you do not have the notification(s), contact the hospital(s) or facility(s) to obtain one.

- 2 DEA registration?

If "YES", provide a detailed summary of the conduct/allegation upon which action was taken. Include the notification from DEA. If you do not have a copy of the notification, contact DEA to obtain a copy.

HAVE YOU PREVIOUSLY REPORTED ANY OF THE ABOVE MATTERS TO THE BOARD?

IF YES, PROVIDE DOCUMENTATION IN SUPPORT OF YOUR RESPONSE. IF APPLICABLE, PROVIDE A COPY OF THE FINAL DISPOSITION FROM THE BOARD.

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).

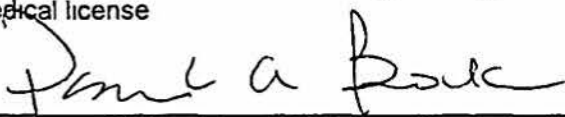
☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

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.


Signature of Physician

4/18/01

Date

PAMELA A. BOCK

36747

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

Renewal - DR.0036747

Name	Pamela Anne Bock
Credential	DR.0036747

Fee Details

Renewal Fee	\$ 2.00
Renewal Fee	\$ 334.00
Renewal Fee	\$ 3.00
Renewal Fee	\$ 18.00
Renewal Fee	\$ 144.00
	\$ 501.00

DR Renewal HPPP**Healthcare Professions Profiling Program ACTIVE status only:**

All ACTIVE status licensees must maintain a Healthcare Professions Profile with current information. Please note that licensees are required to update their Healthcare Professions Profile within 30 days of changes or any reportable events. To access your HPPP account, please go to the HPPP Database by [CLICKING HERE](#) and enter your Login ID and Password for the HPPP system - these may be different from your User ID and password for this account in the Online Services system. Remember, it is your responsibility to maintain the accuracy of your Healthcare Profile within 30 days of any change. Failure to timely update your database may subject your license to disciplinary action.

DR Renewal Questionnaire**PART I: MANDATORY RENEWAL QUESTIONNAIRE**

You must answer "YES" or "NO" to each question below. If you answer "YES" to a question, you must mail a copy of this questionnaire and a detailed explanation to include dates, amounts and contact information, to the Board for each "YES" answer within **thirty (30) days** of submitting your renewal. If the matter has already been disclosed to the Board, you must send a letter to the Board providing the case number and identifying information. If no documentation is received, a case may be opened and a complaint issued for an explanation of each "YES" answer.

SECTION A: SINCE YOU LAST RENEWED YOUR COLORADO MEDICAL LICENSE:

1. Have you 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 health care 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, whether involuntary or in lieu of investigation?

2. Have you surrendered a license or other authorization to practice medicine in another state or jurisdiction, or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?

If you answer YES to question number 2, you must provide a detailed summary of the events which led to the charges or citation. Include a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.

3. Have you, in any state, been denied medical liability insurance, or has your medical liability insurance coverage been limited, restricted or terminated by action of the insurance carrier?

If you answer YES to question number 3, you must provide a copy of the notification from the insurance carrier and a summary of the events which led to the action by the carrier. If you do not have a copy of the notification, contact the insurance carrier to obtain one.

4. Have you had any felony or misdemeanor charges of any kind brought against you? Have you had any traffic citations involving drugs or alcohol brought against you? Regardless of the case disposition, you must answer YES if you have been charged.

If you answer YES to question number 4, you must provide a detailed summary of the events which led to the charges or citation. Include a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.

5. **For question 5, you must answer YES** if any of these actions are currently pending, or if you have withdrawn or failed to proceed with an application for these items.

Has your medical staff membership or clinical privileges at any hospital or healthcare facility been involuntarily or in lieu of investigation reduced, limited, placed on probation, not renewed or relinquished, or been denied, revoked or suspended?

If you answer YES to questions 5, you must provide a detailed summary to the Board of the conduct/allegation upon which action was taken.

No

6. **For question 6, you must answer YES** if any of these actions are currently pending, or if you have withdrawn or failed to proceed with an application for these items.

Has your DEA registration been involuntarily or in lieu of investigation reduced, limited, placed on probation, not renewed or relinquished, or been denied, revoked or suspended?

If you answer YES to questions 6, you must provide a detailed summary to the Board of the conduct/allegation upon which action was taken. And you must include the notification from the DEA. If you do not have a copy of the notification, contact the DEA to obtain a copy.

No

SECTION B IN THE LAST TWO YEARS:

7. Do you now abuse or excessively use, or have you in the last two years abused or excessively used, any habit forming drug, including alcohol, or any controlled substance that has a) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or b) affected your ability to practice as a physician safely and competently?

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

If you answer YES to question 7, you must provide a detailed summary of the behavior, condition or substance use. Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers.

No

8. In the last two years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a physician safely and competently, such as bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder?

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

If you answer YES to question 8, you must provide a detailed summary of the behavior, condition or substance use. Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers.

PART 2: MANDATORY ATTESTATION

9. **By submitting this application for renewal of my license, 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.**

I wish to to renew my license in ACTIVE status, therefore I attest that I meet (or claim exemption from) the financial responsibility standards as indicated below. (select the correct option A-I) If you are currently in Active status an wish to change to Inactive status you cannot renew online and must contact the Division at 303-894-2984.

I am currently in INACTIVE status and am exempt from the provisions above. (If so, you must select option "J"). *If you wish to change to ACTIVE status, you must first renew your license in inactive status, and then submit the reactivation application and fee. The reactivation application is available on the Medical Board website.

Please select only 1 item below.

A. I maintain commercial professional liability insurance with COPIC, in minimum indemnity amounts of at least \$1,000,000 per incident and \$3,000,000 annual aggregate per year.

KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

Review

Renewal - DR.0036747

Name	Pamela Anne Bock
Credential	DR.0036747

Fee Details

Renewal Fee	\$ 2.00
Renewal Fee	\$ 238.00
Renewal Fee	\$ 18.00
Renewal Fee	\$ 162.00
	\$ 420.00

Affidavit of Eligibility - Screening Present

AFFIDAVIT OF ELIGIBILITY

1. Do you currently reside in and are you physically present in the United States?
Yes

Affidavit of Eligibility - Screening Doc Change

AFFIDAVIT OF ELIGIBILITY

2. Are you a United States Citizen and the State or Federally issued document, in which you proved your legal status in the United States is still valid **and** has not expired since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

-OR-

Are you Not a United States Citizen, but are lawfully present in the United States **and** your legal status within the United States has not changed **and** the legal documents used to prove lawful presence have not changed since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

If you need to update your lawful presence information, select no and you will be prompted to complete a new Affidavit of Eligibility. Otherwise, if your information has not changed, select yes to move forward.

Yes

Affidavit of Eligibility

AFFIDAVIT OF ELIGIBILITY

Pursuant to C.R.S. 24-34-107, ALL applicants for original licensure* or licensees renewing or reinstating a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

** The word "licensure" is used as a general term. While most of the professions and occupations are licensed, others may be certified, registered or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.*

3. Please enter your Full Legal Name

Affidavit of Eligibility - Section A

Section A: LAWFUL PRESENCE in the United States

4. Select one of the following Lawful Presence types below and click "Next" when done:

Affidavit of Eligibility - Section B.1

Section B: SECURE AND VERIFIABLE DOCUMENTS

5. Do you have a State or Federal government issued identification?

These include:

- Driver's License or Permit
- Government Issued ID Card
- Valid U.S. Military Common Access Card
- Colorado Department of Corrections Inmate ID
- Tribal ID Card
- U.S. Passport
- Certificate of Naturalization
- Certificate of (U.S.) Citizenship
- Valid Temporary Resident card
- Valid I-94 issued by Canadian government
- Valid I-94 with refugee/asylum stamp

Affidavit of Eligibility - Section B.1 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

6. Select one of the following Government Issued Identification:

7. Enter the name of State or Federal Agency that issued the identification:

8. Enter your full name as shown on the driver's license or State/Federal issued identification:

9. Enter the State/Federal government issued license/ID number:

10. Enter the expiration date of the license/ID:

11. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.2

Section B: SECURE AND VERIFIABLE DOCUMENTS

12. Do you have a Valid I-766 (Employment Identification Card)?

Affidavit of Eligibility - Section B.2 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

13. Enter the issuing Federal Agency:

14. Enter the name as listed on the card:

15. Enter the Alien number (A#):

16. Enter the card number:

17. Enter the Valid From Date:

18. Enter the Expiration Date:

19. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.3

Section B: SECURE AND VERIFIABLE DOCUMENTS

20. Do you have a Valid I-551 (Resident Alien or Permanent Resident Card)?

Affidavit of Eligibility - Section B.3 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

21. Enter the issuing Federal Agency:

22. Enter the name as listed on the card:

23. Enter the Alien Number (A#):

24. Enter the country of birth:

25. Enter the card expiration date:

26. Enter the Residence Since date:

27. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.4

28. Do you have a Valid Foreign Passport with an unexpired Visa with proper classification for work authorization, and an unexpired I-94?

Affidavit of Eligibility - Section B.4 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

29. Enter the issuing foreign country:

30. Enter the Passport Number:

31. Enter the Visa Number:

32. Enter the Visa Class (Examples: J-1, P-1 H-1B, etc.):

33. Enter the Date of Entry:

34. Enter the Until Date:

35. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.5**Section B: SECURE AND VERIFIABLE DOCUMENTS**

36. Do you have a valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa?

Affidavit of Eligibility - Section B.5 if Yes**Section B: SECURE AND VERIFIABLE DOCUMENTS**

37. Enter the issuing foreign country:

38. Enter the Passport Number:

39. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section C**Section C: Attestation**

I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.

I understand that 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 in the second degree, as defined in section 18-8-503, C.R.S. that the above statements are true and correct.

I am the person identified on the previous pages and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.

I understand that the information on the previous pages must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

40. By entering your full legal name below you attest that you have read and understand the above information.

41. Please enter today's date below:

DR Renewal Attestation

The below attestations apply to your license's CURRENT status. You may not change your status through online renewal. To change your status, please contact the licensing office at dora_registrations@state.co.us or 303-894-7800.

By renewing my license in INACTIVE status, I attest that:

I understand malpractice insurance is not required for Inactive license holders; however, 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 two (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.

By renewing my license in ACTIVE status, I attest that:

I have not abused or excessively used any habit forming drug, including alcohol, or any controlled substance that has: 1) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or, 2) affected my ability to practice as a physician safely and competently, at any time during the past two years, up to and including today's date.

AND

In the last two years, I have not been diagnosed with or treated for an illness or condition that significantly disturbs my cognition, behavior, or motor function, and that may impair my ability to practice as a physician safely and competently, such as bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder

OR

The illness or condition or the use of substances, as defined above, is: 1) already known to the Colorado Physician Health Program ("CPHP") and I have made, or will make known within 30 days, any requisite disclosure to the Board pursuant to section 12-36-118.5 and any attendant regulations; or, 2) I have entered into a Confidential Agreement with the Board. For the purpose of this attestation, "Known to CPHP" means that I have informed CPHP of my condition or use of such substances and I am complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

In the last 2 years, no adverse action has been taken against my license by another licensing agency, a peer review body, a health care institution, a residency or postgraduate training program, a professional or medical society or association, a governmental agency, a law enforcement agency, or a court for acts or conduct which, would constitute grounds for disciplinary or adverse actions pursuant to the Medical Practice Act or its attendant rules. For the purpose of this attestation, an adverse action by a law enforcement agency includes: 1) all felony charges; 2) all misdemeanor charges; or, 3) traffic charges/citations involving alcohol, controlled substances, or any other habit-forming drug.

OR

I have reported, or will report within 30 days, any adverse action to the Board in accordance with the requirements of the Medical Practice Act.

In the last 2 years, I have not been denied medical liability insurance and no liability insurance coverage has been limited, restricted, or terminated by action of the insurance carrier in this or any other state.

OR

I have reported, or will report within 30 days, any denial or limitation of medical liability coverage to the Board.

I have established and will continuously maintain professional liability insurance as required by §13-64-301, C.R.S.

Click Next to proceed.

GLOBAL HPPP Renewal Attestation

Pursuant to section 24-34-110, C.R.S., all Active and Retired status licensees must maintain a current Healthcare Professions Profile. Reportable events and/or changes to information must be made within 30 days. For more information about this Program and to update your profile, visit www.dora.colorado.gov/professions/hppp.

By renewing your Active or Retired license, you attest to the following:

I have updated my Healthcare Professions Profile to current date and/or I will make any updates within 30 days of any reportable event or change, and subsequent updates will be made within 30 days. This requirement is in addition to any requirement by a profession's practice act. Examples of reportable events or changes that must be updated on a profile include, but are not limited to, location of practice, public actions issued by any jurisdiction, felonies and crimes of moral turpitude, malpractice settlements/judgments, etc. To update a Healthcare Professions Profile, or for more information on the Healthcare Professions Profile Program (HPPP) and its requirements, visit www.dora.colorado.gov/professions/hppp or call 303-894-5942.

If your status is Inactive you are not required to maintain a Healthcare Professions Profile, click next to proceed.

You may NOT change your status through online renewal. For information regarding a status change, please contact the renewal desk at 303-894-7800 or dora_dpo_renewalline@state.co.us.

Click next to proceed.

Review

Please make sure to [PRINT THIS SCREEN](#) for your records. To do so, you can click the button in the upper right hand corner of this screen labeled "Print Review". You will not be able to print after you leave this review screen.