

Division of Registrations  
Office of Licensing—Medical  
(303) 894-7800 / FAX (303) 894-7693  
www.dora.state.co.us/registrations

Application for Original License  
**PHYSICIAN**  
Fee: \$522

The content of this application must not be changed. If the content is changed,  
the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

**PART 1—APPLICANT INFORMATION**

|  |   |                          |  |         |
|--|---|--------------------------|--|---------|
| Name: Last: <u>KOVICH</u>  | <input checked="" type="checkbox"/> MD<br><input type="checkbox"/> DO   | First: <u>HEATHER</u>    | Middle: <u>C</u>   | Suffix: |
| Previous Name(s):  |   |                          |  |         |
| Social Security Number: *  | Date of Birth (mm/dd/yyyy):   |                          | Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female |         |
| Place of Birth (city and state, or foreign country): <u>Philadelphia, PA</u> |   |                          |  |         |
| Mailing Address:   | PO Box, Street:   | <u>Box 1901</u>          |  |         |
| This is a <input type="checkbox"/> Home <input type="checkbox"/> Business    | City, State, Zip:   | <u>Shiprock NM 87420</u> |  |         |
| Daytime Telephone Number: <u>(206) 940 1039</u>                              | E-mail Address:<br>Preferred method for communication: <input type="checkbox"/> Mail <input checked="" type="checkbox"/> E-mail |                          |  |         |

**PART 2—EDUCATION/TRAINING**

List the name and address of the school where your medical degree was received:

| Name of School           | Location (address and ZIP)       | Years Attended (from / to) | Year of Graduation |
|--------------------------|----------------------------------|----------------------------|--------------------|
| <u>Temple University</u> | <u>3500 N. Broad St Phila PA</u> | <u>19140 2001 - 2005</u>   | <u>2005</u>        |

▶ If this is an international medical school, please provide the country where the school is physically located: \_\_\_\_\_

Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs?  YES  NO

▶ If YES, provide information below:

| Name of Facility                | Specialty              | Years Attended (from / to) |
|---------------------------------|------------------------|----------------------------|
| <u>University of Washington</u> | <u>Family Medicine</u> | <u>2005 - 2008</u>         |

What is your specialty or specialties? Family Medicine

\*Social Security Number Disclosure: Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in Title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's Social Security Number. Disclosure of your Social Security Number is mandatory for purposes of establishing, modifying, or enforcing child support under Sections 14-14-113 and 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by Section 26-13-107(3)(a)(I)(A), C.R.S.; and reporting disciplinary actions to the National Practitioner Data Bank pursuant to 45 CFR Sections 80.1 et seq., and the Health Integrity and Protection Data Bank as required by 45 CFR Sections 81.1 et seq. Failure to provide your Social Security Number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your Social Security Number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your Social Security Number will not be released for any other purpose not provided for by law.

OFFICE USE ONLY: LICENSE NUMBER: 49599 DATE ISSUED: 01/06/11

APPLICANT NAME: Heather Krich

**PART 3—EXAMINATION / CERTIFICATION**

List name of licensing exam(s): ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam.

| Exam            | Location   | Date    | Result |
|-----------------|------------|---------|--------|
| USMLE Step 1    | Phila. PA  | 6/21/03 |        |
| USMLE Step 2    | Phila PA   | 8/7/04  |        |
| USMLE Step 2 CS | Phila PA   | 10/2/04 |        |
| USMLE Step 3    | Seattle WA | 9/7/06  |        |

▶ If this is an international medical school, please provide the country where the school is physically located: \_\_\_\_\_

Are you Board certified by either the American Board of Medical Specialties or the American Osteopathic Association?  YES  NO

▶ If YES, list certification information: \_\_\_\_\_

**PART 4—LICENSE INFORMATION**

A. Have you ever been licensed to practice medicine in any state, territory, district, or country? (include temporary licenses and educational permits)  YES  NO

▶ If YES, provide a complete list of all medical licenses (if needed, attach an additional sheet in the same format):

| Type of license | State/Country | License Number | Year license issued  | Disciplinary action against license?                                | Is this license current/active?                                     |
|-----------------|---------------|----------------|----------------------|---|---|
| medical         | WA            | 00048623       | 2009 <sup>2007</sup> | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
|                 |               |                |                      | <input type="checkbox"/> YES <input type="checkbox"/> NO            | <input type="checkbox"/> YES <input type="checkbox"/> NO            |
|                 |               |                |                      | <input type="checkbox"/> YES <input type="checkbox"/> NO            | <input type="checkbox"/> YES <input type="checkbox"/> NO            |

B. Have you ever applied for any type of Colorado health care license prior to this application?  YES  NO

▶ If YES, provide application types and license information if applicable:

| Application type | License Number | Month and year license issued |
|------------------|----------------|-------------------------------|
|                  |                |                               |
|                  |                |                               |

**PART 5—MALPRACTICE INSURANCE CERTIFICATION**

You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado law, or claim one of the exemptions set forth in the enclosed insurance memo. See instructions in the insurance memo, 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: 2a - federal civilian physician - practice limited to federal agency

APPLICANT NAME: Heather Kind

**PART 6—SCREENING QUESTIONS**

1. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic licensing board of any complaint, investigation, or inquiry which is currently pending?  YES  NO  
▶ 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.

| Agency | Date | Charge | Disposition |
|--------|------|--------|-------------|
|        |      |        |             |

2. 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.  YES  NO  
▶ 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.

| Agency | Date | Charge | Disposition |
|--------|------|--------|-------------|
|        |      |        |             |

3. Have you ever entered into any agreement with any state, territory, district, country, U.S. government agency, and state medical/osteopathic board regarding your medical license?  YES  NO  
▶ 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.

| Agency | Date | Reason |
|--------|------|--------|
|        |      |        |

4. 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 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.

| Agency | Date | Reason for Denial |
|--------|------|-------------------|
|        |      |                   |

5. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in any other state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee.  YES  NO  
▶ 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.

| Agency | Date | Reason |
|--------|------|--------|
|        |      |        |

**PART 6—SCREENING QUESTIONS (Continued)**

6. Have either your medical staff membership or clinical privileges at any hospital or healthcare facility or your DEA registration been voluntarily or involuntarily reduced, limited, placed on probation, not renewed or relinquished or have either been denied, revoked or suspended? You must answer YES if any of these actions are currently pending. You must answer YES if you have withdrawn or failed to proceed with an application for these items.  YES  NO

▶ If YES, summarize below AND request hospital or DEA to submit a report directly to the Board regarding the action. Also submit your narrative regarding the action taken.

| Name of Facility | Date | Reason for Action |
|------------------|------|-------------------|
|                  |      |                   |

7. 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, pardoned, or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.

▶ 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.

| Date | Court | Violation | Penalty or Disposition |
|------|-------|-----------|------------------------|
|      |       |           |                        |

8. Do you now abuse or excessively use, or have you in the last five 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?

9. In the last five 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 to Question 8 or 9 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.

If you answer YES to Question 8 or 9, submit detailed information to the Board that will allow the Board to assess your ability to practice safely, competently, and without impairment to your professional judgment, skill, or knowledge. In addition to that information, you are required to provide copies of any related records, reports, evaluations, police reports, probation reports, and court records directly to the Board.

Please be advised that an affirmative response to Question 8 or 9 may result in a request from the Board for evaluation by the Colorado Physician Health Program (CPHP). The CPHP evaluation process could potentially delay consideration of an application. Therefore, the Board is providing advance notice of this possibility so that applicants may contact CPHP to schedule an evaluation at the beginning of the application process. By doing so, the application for licensure should not be unduly delayed. An applicant is not required to contact CPHP in advance of Board consideration of the application. The applicant may choose to wait for a specific decision by the Board that a CPHP evaluation is necessary. This information is being provided to put applicants on notice with respect to this potential requirement and afford the applicant the opportunity to expedite the process if he or she so desires. (Colorado Physicians Health Program – CPHP, 899 Logan Street, #410, Denver, CO 80203; 303-860-0122.)

APPLICANT NAME: Heather Knich

**PART 6—SCREENING QUESTIONS (Continued)**

10. 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  NO

▶ If YES, summarize below AND submit to the Board a completed malpractice Claims Information Form (attached) and a clinical narrative regarding your involvement in the case.

| Date | Name and Address of Insurance Company | Reason for Action |
|------|---------------------------------------|-------------------|
|      |                                       |                   |
|      |                                       |                   |

11. 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  NO

▶ 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.

**ATTESTATION**

I 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), which includes state medical licensing boards and the Federation of State Medical Boards, to release to the licensing Board any information, files or records requested by the Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine during the processing of this application and the time that I am a licensee of this Board.

I state under penalty of perjury in the second degree, as defined in C.R.S. 18-8-503, that the information contained in this application is true and correct to the best of my knowledge. In accordance with C.R.S. 18-8-501(2)(a)(I), false statements made herein are punishable by law and may constitute violation of the practice act.

Heather Knich 10/30/10  
Signature of Applicant Date

Colorado Division of Registrations  
Office of Licensing—Medical

1560 Broadway, Suite 1350  
Denver, CO 80202

Phone: (303) 894-7800 / FAX: (303) 894-7693

[www.dora.state.co.us/registrations](http://www.dora.state.co.us/registrations)

DIV. OF REGISTRATIONS 892

DEC 27 10 / 09 52

**REPORT OF PRACTICE HISTORY**

(See instructions on following page)

| Dates of Practice<br>From To<br>mm/yyyy mm/yyyy |                | Facility Name                                    | Address<br>(Street & Number, City, State, ZIP) | Reference<br>(Name and Title)          | Nature of Practice                                    |
|---|----------------|--|--|--|---|
| 6/05  | 6/08           | U. Washington Family<br>Medicine Residence       | 4245 Roosevelt Ave NE<br>Seattle WA 98105      | Julie Sawvel, MD<br>program director   | family medicine<br>resident                           |
| 7/08-<br>4/09                                   | 10/08-<br>8/09 | MDSI physician staffing                          | 1701 W 2450 South<br>Ogden UT 84401            | Pauline Burgess<br>physician scheduler | independent medical<br>examiner for disability exams  |
| 10/08   | 3/09           | NZ Loums   | Po Box 547<br>Wellington 6140 NZ               | Kerry Mackay<br>physician scheduler    | rural general practice<br>outpatient medicine         |
| 9/09  | current        | Indian Health Service<br>Northern Navajo Med Ctr | Highway 491 / Box 100<br>Shiprock NM 87420     | Sara Michael<br>Chair, family medicine | inpatient, outpatient<br>obstetrics, adult & children |
|   |                |  |  |  |   |
|   |                |  |  |  |   |
|   |                |  |  |  |   |
|   |                |  |  |  |   |
|   |                |  |  |  |   |
|   |                |  |  |  |   |
|   |                |  |  |  |   |

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 Colorado Revised Statutes 18-8-503, 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.

*Kovitch*
KOVITCH
12/21/10
Date



Colorado Division of Registrations  
Office of Licensing - Medical  
1560 Broadway, Suite 1350  
Denver, CO 80202

NZLocums  
PO Box 547  
Wellington, 6140

November 1, 2010

To Whom It May Concern,

**Re: Dr Heather Kovich, verification of placements worked through NZLocums 2008/2009.**

This is to confirm that Dr Heather Kovich worked as a full-time Locum General Practitioner in New Zealand from October 2008 – March 2009. Please see below for further information.

| Practice                    | Start date                     | End date                       | Approx. Roster   |
|-----------------------------|--------------------------------|--------------------------------|--|
| Barraud St Health Centre    | 27 <sup>th</sup> October 2008  | 21 <sup>st</sup> November 2008 | Monday to Friday – Morning and Afternoon sessions + some on-call |
| Moerewa Medical Centre      | 24 <sup>th</sup> November 2008 | 19 <sup>th</sup> December 2008 | Monday to Friday – Morning and Afternoon sessions + some on-call |
| Cromwell Medical Centre     | 29 <sup>th</sup> December 2008 | 16 <sup>th</sup> January 2009  | Monday to Friday – Morning and Afternoon sessions + some on-call |
| Morrinsville Medical Centre | 27 <sup>th</sup> January 2009  | 5 <sup>th</sup> February 2009  | Monday to Friday – Morning and Afternoon sessions + some on-call |
| Te Kauwhata Medical Centre  | 9 <sup>th</sup> February 2009  | 20 <sup>th</sup> February 2009 | Monday to Friday – Morning and Afternoon sessions + some on-call |
| Roxburgh Medical Centre     | 23 <sup>rd</sup> February 2009 | 27 <sup>th</sup> February 2009 | Monday to Friday – Morning and Afternoon sessions + some on-call |
| Golden Bay Medical Centre   | 3 <sup>rd</sup> March 2009     | 13 <sup>th</sup> March 2009    | Monday to Friday – Morning and Afternoon sessions + some on-call |

Dr Kovich received above satisfactory Supervision Reports for the above practices. Please feel free to contact me should you require any further information.

Kind regards,

Kerry Mackay  
Relationship Manager - NZLocums

(3)

Colorado Division of Registrations  
Office of Licensing—Medical  
1560 Broadway, Suite 1350  
Denver, CO 80202  
Phone: (303) 894-7800 / FAX: (303) 894-7693

**CERTIFICATE OF MEDICAL EDUCATION**

**SECTION 1**

To be completed by applicant and forwarded to school where medical degree was received.

This certifies that Heather Kovich  
Full Name of Applicant

enrolled in Temple U. School of Medicine  
Full Name of School

Philadelphia PA, USA on the      day of August, 2001  
Location of School Day Month Year

**SECTION 2**

To be completed by president / secretary / dean of medical school and forwarded to the Office of Licensing.

The undersigned certifies that the records of this institution show that s/he attended this institution  
beginning on the 4th day of September, 2001 and was granted the degree  
Day Month Year

Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 19th day of May, 2005  
Day Month Year

Signed and the college seal affixed

This 22nd day of November, 2010  
Day Month Year

By *James E. Stinson*  
President Director  
OFFICE OF FACULTY & STUDENT RECORDS

**NOT VALID WITHOUT SCHOOL SEAL**

**NOTE TO REGISTRAR:**

If no school seal, please indicate above next to signature of President/Secretary/Dean.

**RECEIVED**

DEC 9 2010

OFFICE OF FACULTY & STUDENT RECORDS  
SCHOOL OF MEDICINE

L2





STATE OF WASHINGTON  
DEPARTMENT OF HEALTH  
MEDICAL QUALITY ASSURANCE COMMISSION  
PO Box 47866, Olympia, WA 98504-7866

November 09, 2010

STATE OF COLORADO  
1560 BROADWAY STE 1350  
DENVER CO.80202

Subject: Credential Verification

To Whom It May Concern:

This will verify the status of the Physician And Surgeon License for HEATHER KOVICH.

*Sections may be blank because the information is not in our database or is not applicable for this credential type.*

**Year of Birth:**  
**Credential Number:** MD.MD.00048623  
**Credential Type:** Physician And Surgeon License  
**Current Credential Status:** ACTIVE ACTIVE ✓  
**First Credential Date:** 07/27/2007  
**Expiration Date:** 03/07/2011 ✓  
**Last Renewal Date:**  
**Examination:**  
**Exam Level:**  
**Score:**

**Our records above show that the licensee has not been disciplined, the licensee is considered in good standing ✓**

Please call me at (360) 236-2766 if you have questions or visit our Online Provider Credential Search at [www.doh.wa.gov](http://www.doh.wa.gov).

*Betty Elliott*

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Betty Elliott, Acting Licensing Manager



**AFFIDAVIT OF ELIGIBILITY**

Pursuant to H.B. 06S-1009, C.R.S 24-34-107, **ALL** applicants for original licensure or licensees renewing a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

**Section A: LAWFUL PRESENCE in the United States.**

I, (please print your full name) Heather Kovich, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check 1, 2 or 3 below):

1.  I am a US citizen.
2.  I am not a US citizen but am lawfully present in the US as evidenced by one of the following
  - a.  I am a qualified alien as defined in 8 U.S.C. sec 1641.
  - b.  I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended.
  - c.  I am an alien who is paroled into the US under 8 U.S.C. sec. 1182 (d) (5).
3.  I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
  - a.  I am a US citizen, not physically present or employed in the United States.
  - b.  I am a Foreign National, not physically present or employed in the United States.

*If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.*

**Section B: Secure and Verifiable Document.** This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided upon request only.
  - Any Colorado Driver License, Colorado Driver Permit or Colorado Identification Card, expired less than one year. (Temporary paper license with invalid Colorado Driver License, Colorado Driver Permit, or Colorado Identification Card, expired less than one year is considered acceptable.)
  - Out-of-state issued photo Driver's License or photo identification card, photo driver's permit expired less than one year.
  - Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa.
  - Valid I-551 Resident Alien or Permanent Resident card.
  - Valid foreign passport accompanied by an "I-94" indicating a specific future "until" date.
  - Valid I-94 issued by Canadian government with L1 or R1 status and a valid Canadian driver's license or valid Canadian identification card.
  - Valid Temporary Resident Card.
  - Valid I-94 with refugee/asylum stamp.

(document list continued on page 2)

- Valid 1688B or 1766 Employment Authorization Card.
- Valid US Military ID (active duty, dependent, retired, reserve and National Guard).
- Tribal Identification Card with intact photo (US or Canadian).
- Certificate of Naturalization with intact photo.
- Certificate of (US) Citizenship with intact photo.
- Passport issued by the U.S. Government with one of the following documents: Social Security card; marriage, divorce or separation certificate or decree; or a Colorado or Federal tax return.
- Colorado Department of Corrections Inmate Identification Card with a Social Security card issued by the United States Government.

2. Enter the state or the federal agency name where this secure and verifiable document was issued.  
New Mexico Motor Vehicle Dept  
(If issued by a state agency, include both the state and agency name.)

3. What is the secure and verifiable document number? 510082982

4. What is the expiration date of your secure and verifiable document? 12 11 10 (month/day/year)  
(If you hold a document without an expiration date, such as a military ID or naturalization certificate, write N/A.)

**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 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified above 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 above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Signature Kend MP

Date 11/8/10

Heather C Kvich  
 Please print your name as shown on your secure and verifiable document.

Professional License Type: Washington State MD

License Number (if already licensed): MD 00048623

**Renewal - DR.0049599**

|            |                      |
|------------|----------------------|
| Name       | Heather Clare Kovich |
| Credential | DR.0049599           |

**Fee Details**

|             |                 |
|-------------|-----------------|
| Renewal Fee | \$2.00          |
| Renewal Fee | \$334.00        |
| Renewal Fee | \$3.00          |
| Renewal Fee | \$18.00         |
| Renewal Fee | \$144.00        |
|             | <b>\$501.00</b> |

**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?

No

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.

No

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.

No

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.

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.**

G. 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. Choose this option if your employer provides self insurance or trust coverage, or you are a Colorado State public employee covered under the Colorado Governmental Immunity Act.

KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

## **Review**

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**Renewal - DR.0049599**

|            |                      |
|------------|----------------------|
| Name       | Heather Clare Kovich |
| Credential | DR.0049599           |

**Fee Details**

|             |                 |
|-------------|-----------------|
| Renewal Fee | \$2.00          |
| Renewal Fee | \$238.00        |
| Renewal Fee | \$18.00         |
| Renewal Fee | \$162.00        |
|             | <b>\$420.00</b> |

**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**

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**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**

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**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**

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**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**

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#### **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**

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#### **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**

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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**

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#### **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**

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#### **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**

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#### **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**

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#### **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**

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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](mailto: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](http://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](http://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](mailto: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.



**Renewal - DR.0049599**

|            |                      |
|------------|----------------------|
| Name       | Heather Clare Kovich |
| Credential | DR.0049599           |

**Fee Details**

|                         |                 |
|-------------------------|-----------------|
| DR - Legal Defense Fund | \$2.00          |
| DR - PDMP Fee           | \$24.00         |
| DR - Portal Fee         | \$1.50          |
| DR - Renewal Fee Active | \$238.50        |
| DR- Peer Fee            | \$162.00        |
|                         | <b>\$428.00</b> |

**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

**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](mailto: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:**

- In the past two years I have not abused or excessively used any habit forming drug including, alcohol or any controlled substance, and I have not been diagnosed with or treated for a condition that disturbs my cognition, behavior or motor function which has resulted in an adverse action, a professional disciplinary action, a criminal charge, or an allegation or finding of working impaired, diversion of controlled substances or habit -forming medications (including self-prescribing), sexual contact with a patient, substandard medical practice or patient harm.

OR

In the past two years I have abused or excessively used any habit forming drug including, alcohol or any controlled substance, or I have been diagnosed with or treated for a condition that disturbs my cognition, behavior or motor function

which has resulted in an adverse action, a professional disciplinary action, a criminal charge, or an allegation, or finding of working impaired, diversion of a controlled substance or habit-forming medication (including self-prescribing), sexual contact with a patient, substandard medical practice or patient harm AND I have reported, or will report this information within 30 days to the Colorado Medical Board.

- 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 two years, I have not been diagnosed with or treated for an illness, condition or behavior, that disturbs my cognition, behavior, or motor function that has resulted in conduct which may impair my ability to practice as a physician, safely and competently, such as substance misuse or abuse, bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder.

OR

In the last two years, I have been diagnosed with or treated for an illness, condition or behavior that significantly disturbs my cognition, behavior, or motor function that has resulted in conduct which may impair my ability to practice as a physician, safely and competently, such as substance misuse or abuse, bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder AND:

1) The illness or condition is 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; OR

3) I have reported, or will report within 30 days, the illness or condition to the Medical Board.

- 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.

## HPPP - DR Introduction

### Healthcare Professions Profile

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Please be aware that this profile is only for your Physician license. Do not provide information for other license types you hold on this profile. You will be required to complete a profile for every license you hold that is included in the profiling requirement.

All information provided in this profile must be updated within 30 days of any change of information unless your profession's statute says otherwise, or unless the question specifies otherwise.

## HPPP GLOBAL - Location of Practice

### Location of Practice

49. Are you currently practicing in the healthcare profession associated with this profile?

Yes

**HPPP GLOBAL - Location of Practice If Yes**

**Location of Practice**

50. Practice Locations:

| Address            | City     | State      | Zip Code | Phone Number   |
|--------------------|----------|------------|----------|----------------|
| PO Box 160/Hwy 491 | Shiprock | New Mexico | 87420    | (505) 368-6001 |
| 46 Suttle St       | Durango  | Colorado   | 81303    | (970) 247-3002 |

**HPPP - MEDICAL Education and Training**

**Education and Training**

51. School or Education Level:

Temple University School of Medicine

52. Please enter the year your initial Degree was achieved: *Only enter the year in YYYY format*

2005

**HPPP GLOBAL - Other Licenses**

**Other Licenses**

53. Have you ever held, or do you currently hold any other licenses in this profession from any other state, country or province?

Yes

**HPPP GLOBAL - Other Licenses if Yes**

**Other Licenses**

54. Other Licenses:

| State      | License Status | Year Originally Issued |
|------------|----------------|------------------------|
| Washington | Expired        | 2009                   |

**HPPP GLOBAL - Board Certifications**

**Board Certifications**

55. Do you hold any current Board Certifications?

Yes

**HPPP - MEDICAL Board Certifications if Yes**

**Board Certifications**

56. Board Certifications:

| Certification |
|---------------|
|               |

Family Medicine

**HPPP GLOBAL - Practice Specialties**

**Practice Specialties**

57. Do you have a practice specialty in which you are appropriately trained and actively practicing?

Yes

**HPPP - MEDICAL Practice Specialties if Yes**

**Practice Specialties**

58. Practice Specialties:

| Specialty       |
|-----------------|
| Family Medicine |

**HPPP GLOBAL - CO Hospital Affiliations**

**Colorado Hospital Affiliations**

59. Do you have a current affiliation or clinical privileges with any Colorado Hospital?

No

**HPPP GLOBAL - Other Hospital Affiliations**

**Other Health Care Facilities and Out of State Hospital Affiliations**

61. Do you have a current affiliation with any healthcare facility or a non-Colorado hospital?

Yes

**HPPP GLOBAL - Other Hospital Affiliations If Yes**

**Other Health Care Facilities and Out of State Hospital Affiliations**

62. Other Healthcare Facility Affiliations:

| Facility                       | Affiliation Type     | City     | State      |
|--------------------------------|----------------------|----------|------------|
| Northern Navajo Medical Center | Admitting Privileges | Shiprock | New Mexico |

**HPPP GLOBAL - Business Ownership**

**Business Ownership**

63. Do you have a current business ownership interest in any healthcare-related business?

No

**HPPP GLOBAL - Employer**



**Employer**

65. Do you have an employer in the profession in which you are licensed or are applying for a license?

Yes

**HPPP GLOBAL - Employer if Yes****Employer**

66. Employer:

| Employer Name                  | Address            | City     | State      | Zip Code | Phone Number   |
|--------------------------------|--------------------|----------|------------|----------|----------------|
| Northern Navajo Medical Center | PO Box 160 Hwy 491 | Shiprock | New Mexico | 87420    | (505) 368-7012 |

**HPPP GLOBAL - Employment Contracts****Employment Contracts**

67. Do you have a contract with any business whose mission relates to healthcare services or products where the value is greater than \$5000 annually?

No

**HPPP GLOBAL - Disciplinary Actions****Disciplinary Actions**

69. Have you ever had public disciplinary action taken against your license by any board or licensing agency in any state or country?

No

**HPPP GLOBAL - Restrictions and Suspensions****Restrictions and Suspensions**

71. Have you ever entered into any agreement or stipulation to temporarily cease your practice or had a board order issued restricting or suspending your license?

No

**HPPP GLOBAL - Healthcare Facility Actions****Healthcare Facility Actions**

73. Since September 1, 1990, have you had any final actions resulting in involuntary limitations or probationary status on or reduction, nonrenewal, denial, revocation or suspension of medical staff membership or clinical privileges at a hospital or healthcare facility? You are not required to report a precautionary or administrative suspension unless you resigned your medical staff membership or clinical privileges while the suspension was pending.

No

**HPPP GLOBAL - Termination of Employment**

**Termination of Employment**

75. Have you ever been terminated by an employer for a reason that would be considered a violation of your profession's practice law?

No

**HPPP GLOBAL - DEA Registration**

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**DEA Registration Surrender**

77. Have you ever had to involuntarily surrender your United States Drug Enforcement Agency Administration Registration?

No

**HPPP GLOBAL - Convictions**

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**Convictions**

80. Since you were issued a license to practice your profession in any state or country, have you had any final criminal conviction(s) or plea arrangement(s) resulting from the commission or alleged commission of a felony or crime of moral turpitude in any jurisdiction?

No

**HPPP GLOBAL - Malpractice Claims**

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**Malpractice Claims**

82. Since September 1, 1990, have you had any final judgment, entered into a settlement, or paid an arbitration award for malpractice?

No

**HPPP GLOBAL - Malpractice Carrier Refusal**

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**Malpractice Carrier Refusal**

84. Have you been denied liability insurance, or has your liability insurance coverage been limited, restricted or terminated by the insurance carrier?

No

**HPPP GLOBAL - Optional Narrative**

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**Optional Narrative**

86. Optional Narrative:

**HPPP GLOBAL - Attestation**

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**Attestation**

By submitting this Healthcare Professions Profile to the Division of Professions and Occupations you are attesting that:

- You are the person identified in this profile; or
- You are authorized to submit information on behalf of the person identified in this profile; and
- The information contained herein is true and correct to the best of my knowledge.

87. Submission Date:

03/19/2017

### **Review**

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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.