

JUN 21 2004

COLORADO STATE BOARD OF MEDICAL EXAMINERS
APPLICATION FOR A LICENSE TO PRACTICE MEDICINE FEE \$425.00

READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS APPLICATION. ALL QUESTIONS ON THIS APPLICATION MUST BE ANSWERED, AND ALL SUPPORTING DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION PER INSTRUCTIONS. THE ENCLOSED CHECKLIST IS PROVIDED FOR YOUR CONVENIENCE. PLEASE TYPE OR PRINT NEATLY. WHEN SPACE PROVIDED IS INSUFFICIENT, ATTACH ADDITIONAL SHEETS OF PAPER. YOU MAY REPRODUCE THESE BLANK FORMS AS NEEDED, BUT EACH COMPLETED FORM YOU SUBMIT MUST BE IN ORIGINAL INK OR TYPE. **MAKE SUFFICIENT COPIES OF ALL FORMS BEFORE YOU BEGIN.**

1 a. Name: Last BERNSTEIN First ROCHELLE Middle SARA Degree MD				1b. Social Security Number	
2. Other names (i.e. maiden name)- indicate if none. none			What is your speciality(s) OB/GYN		
3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE, Address provided is, by law, public information.)					
<input type="checkbox"/> Home 40 HIGH COUNTRY HEALTH CARE P.O. BOX 1292 <input checked="" type="checkbox"/> Business 620 MAIN STREET, #12					
City FRISCO		State CO		Zip 80443 Country USA	
e-mail address:					
4. Telephone Number: (Area Code) Day (303) 388-9171 Evening same			5. Date of Birth: Mo/Day/Year same Place of Birth same		
6. Sex Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>		7. Have you ever filed an application in Colorado? <input type="checkbox"/> Yes If yes, give date of previous application <input checked="" type="checkbox"/> No			
8. List name/address of the school where medical degree was received. Request an original L2 Form (Certificate of Medical Education - Certificate must be sent directly from the school to this office.)					
Name of School		Address and Zip		Period of Attendance	
				From (Mo/Yr)	To (Mo/Yr)
UNIVERSITY OF COLORADO		4200 EAST NINTH AVE		8/1997	5/2000
HEALTH SCIENCES CENTER		DENVER 80262			
9. List name of licensing exam(s): ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam. Request certification of scores from examining agency be sent directly to this office.					
Exam		Location		Date	
USMLE STEP 1		DENVER, CO		6/1997	
" " 2		DENVER, CO		10/1999	
" " 3		CONNECTICUT		1/2002	
10. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs? <input checked="" type="checkbox"/> Yes If yes, provide information below. <input type="checkbox"/> No					
Name of facility		Specialty		Period of attendance	
				From (Mo/Yr)	To (Mo/Yr)
UNIVERSITY OF CONNECTICUT		OB/GYN		7/2000	6/2004
11. Are you Board Certified by either the American Board of Medical Specialties or the American Osteopathic Association? <input type="checkbox"/> Yes, if yes, list certification information. <input checked="" type="checkbox"/> No					

L1A

Official Use Only	License # 42827	Date 7-19-04
Revised 10/99	Fee \$	Date:

PAID
\$425.00 A.M.
(8342)

12. Are you now or have you ever been licensed to practice medicine in any state, territory, district or country? Include temporary licenses and educational permits. Request verification from each to be sent to the Colorado Board.

Yes If yes, provide information below.
 No

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

13. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic board of any complaint, investigation or inquiry, which is **currently pending**?

Yes If yes, give details below.
 No

State	Date	Charge	Disposition

14. Has **any disciplinary action** ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity? (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question.

Yes If yes, give details below.
 No

State	Date	Charge	Disposition

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

Yes If yes, give details below:
 No

Agency	Date	Reason

16. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination in any state, country, or US federal jurisdiction?

Yes If yes, give details below:
 No

Agency	Date	Reason for denial

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

Yes If yes, explain on a separate sheet, summarize below:
 No

Agency	Date	Reason

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

Yes If yes, explain on a separate sheet, provide copy of resignation letter or hospital action and summarize below:
 No

Name of facility	Date	Reason for action

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

Yes If yes, explain on a separate sheet. Summarize details below:
 No

Date	Court	Violation	Penalty or disposition

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

Yes If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of behavior or condition involved, and what if anything has been done to correct the behavior or condition.

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

Yes If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of behavior involved, and what if anything has been done to correct the behavior.

22. Within the last five years,

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

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

Yes If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of disorder involved, and what if anything has been done to treat the disorder.

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

Yes If yes, list below and complete the enclosed Claims Information Form.
 No

Date	Name and address of Insurance Company	Reason for Action

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

Yes, If yes, explain on a separate sheet and provide verification from insurance company or state licensing board.
 No

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

EXEMPTION CLAIMED: I currently reside outside of Colorado and claim exemption D. L1C

NOTE: ALL ITEMS IN THIS APPLICATION ARE MANDATORY; NONE ARE VOLUNTARY. FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE. The information provided will be used to determine qualification for licensure, per Section 12-36-107 and Section 12-36-111, C.R.S., which authorize the collection of this information. Applicants have the right to review their application subject to the provisions of the Colorado Open Records Act. The Program Administrator of the Colorado State Board of Medical Examiners is the custodian of records.

I, ROCHELLE BERNSTEIN hereby make application for a license to practice medicine in the State of Colorado. In so doing, I authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associations (past and present), and all government agencies (local, state, federal and foreign) to release to the Colorado State Board of Medical Examiners or its successors any information, files or records requested by the Board relative to my qualifications as a physician and my eligibility for licensure.

In accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law.

I state under penalty of perjury, as defined in 18-8-503, C.R.S., that the information contained this application is true and correct to the best of my knowledge. I further state that I have read all disclosures contained in the application packet including the one related to social security numbers.

I understand that under the Colorado Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license and that application fees are not refundable.


Signature

6/20/04
Date

RETURN THIS APPLICATION TO:

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

L1D

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS

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

Department of Regulatory Agencies

Richard F. O'Donnell
 Executive Director

Division of Registrations

Rosemary McCool
 Director



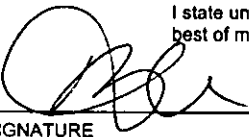
Bill Owens
 Governor

REPORT OF PRACTICE HISTORY

Facility Name	Address and Zip	Reference (name and title)	Dates of Practice From-To	Nature of Practice
1. UNIVERSITY OF CONNECTICUT	FARMINGTON, CT 06030-1925	STEPHEN CURRY, MD PROGRAM	7/2000- 6/2004	OBGYN Residency
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

PLEASE BE AWARE THAT IN COLORADO SUPPLYING FALSE INFORMATION IN AN APPLICATION FOR A LICENSE IS PUNISHABLE BY LAW.

I state under penalty of perjury in the second degree, as defined in 18-8-503, Colorado Revised Statutes, that the information contained in this application is true and correct to the best of my knowledge. I understand that under the Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.


 SIGNATURE

BERNSTEIN
 PRINT LAST NAME

6/15/04
 DATE

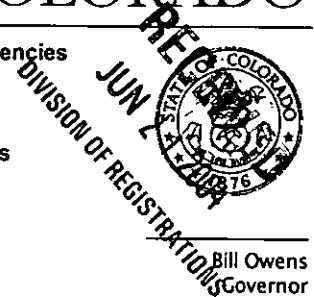
L6

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
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Denver, Colorado 80202-5146
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Department of Regulatory Agencies
Richard F. O'Donnell
Executive Director

Division of Registrations
Rosemary McCool
Director



Bill Owens
Governor

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies
that

ROCHELLE BERNSTEIN
FULL NAME OF APPLICANT

enrolled in

UNIVERSITY OF COLORADO HEALTH
FULL NAME OF MEDICAL SCHOOL

SCIENCES CENTER, DENVER, CO on the 25th day of August
19 97

LOCATION OF MEDICAL SCHOOL

THIS SECTION TO BE COMPLETED BY PRESIDENT/SECRETARY/DEAN OF MEDICAL
SCHOOL AND FORWARDED TO COLORADO BOARD OF MEDICAL EXAMINERS. .
COMPLETE ALL BLANKS IN THE SECTION OR FORM WILL BE RETURNED.

The undersigned certifies that the records of this institution show that he/~~she~~ attended this
institution beginning on the 25th day of August, 1997 and was granted the degree
Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 27 day of MAY,
2000.

Signed and the college seal affixed

This 17th day of June, 2004

By Rhianne Lee McCool

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:

IF NO SCHOOL SEAL, PLEASE INDICATE ABOVE, NEXT TO SIGNATURE OF
PRESIDENT/SECRETARY/DEAN.

L2

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
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Department of Regulatory Agencies
Richard F. O'Donnell
Executive Director
Division of Registrations
Rosemary McCool
Director



RECEIVED

JUN 17 2004

DIVISION OF REGISTRATIONS

Bill Owens
Governor

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

THIS SECTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO THE FACILITY WHERE POSTGRADUATE TRAINING WAS RECEIVED AND/OR COMPLETED

This certifies that ROCHELLE BERNSTEIN
FULL NAME OF APPLICANT

a graduate of UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER
FULL NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in UNIVERSITY OF CONNECTICUT SCHOOL OF MEDICINE
NAME AND ADDRESS OF FACILITY FARMINGTON, CT

TO BE COMPLETED BY THE PROGRAM DIRECTOR OF THE FACILITY FOR ACGME/AOA POSTGRADUATE TRAINING IN THE UNITED STATE OR CANADA. PLEASE TYPE OR PRINT.

on July 1, 2000 and satisfactorily completes such training on June 30, 2004

This training consisted of 48 months of actual clinical instruction and is approved by the Accredited Council for Graduate Medical Education (ACGME), the American Osteopathic association (AOA), or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

List type and length of training.
ROTATION

LENGTH OF ROTATION

WAS THIS PHYSICIAN'S PERFORMANCE COMPLETELY SATISFACTORY? YES NO PLEASE CHECK ONE

IF NO, PLEASE ATTACH AN EXPLANATION.

I hereby declare under penalty of perjury under the laws of the State of Colorado that the above statements are true and correct and the facility is approved by the ACGME/AOA or the CCME to offer the type of level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

PROGRAM DIRECTOR John F. Greene Jr MD

ADDRESS University of Connecticut Farmington, CT 06030

PHONE NUMBER (860) (79-2853) DATE 6/15/04

SIGNATURE John F. Greene Jr

L3

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS

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DISCIPLINARY ACTION REPORT

PLEASE COMPLETE ALL BLANKS ON THIS FORM AND MAIL TO:

FEDERATION OF STATE MEDICAL BOARDS
PO Box 619850
DALLAS, TX 75261-9850

Phone: 817-868-4000
Fax: 817-868-4099

****NO FEE REQUIRED****

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

JUN 15 2004

Dale L. Austin
DALE L. AUSTIN
SENIOR VICE PRESIDENT
AND CHIEF OPERATING OFFICER

The Federation of State Medical Boards maintains a national databank of all disciplinary action taken by state licensing boards and/or other credentialing agencies. To complete your application we must have a report from the Federation. Please note: an unfavorable report does not automatically disqualify you from licensure in Colorado.

NAME ROCHELLE BERNSTEIN
ADDRESS 2 TUNXIS STREET
CITY, STATE AND ZIP CODE FARMINGTON, CT 06032
DATE OF BIRTH 9/5/68
SOCIAL SECURITY NUMBER _____
MEDICAL SCHOOL UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER
DATE OF GRADUATION 5/27/2000

I hereby authorize and request that the Federation of State Medical Boards of the United States Inc. provide a disciplinary history to the State of Colorado Board of Medical Examiners

Signature

6/13/04

Date

L7

Rochelle Bernstein
2 Tunxis Street
Farmington, CT 06032

Colorado Board of Examiners
1560 Broadway, Ste 1350
Denver, CO 80202-5146

To Whom it May Concern:

6/13/04

I am currently applying for licensure to practice medicine as an OBGYN in Colorado. I will complete my residency training with the University of Connecticut, in Farmington, CT on June 17, 2004. I claim to be exempt from malpractice insurance at this time for the following reasons:

I currently reside outside of Colorado
I have not practiced medicine in Colorado
I do not have pending malpractice issues against my training

I will have malpractice insurance that will be effective when I begin my practice in Colorado.

Thank you.

Sincerely,

A handwritten signature in black ink, appearing to be 'R Bernstein', written over a circular stamp or mark.

Rochelle Bernstein, MD



University of Connecticut Health Center
School of Medicine

RECEIVED

JUN 22 2004

DIVISION OF REGISTRATIONS

06/15/04

RE: ROCHELLE BERNSTEIN

To Whom It May Concern:

EXPLANATION OF MALPRACTICE LIABILITY COVERAGE FOR
RESIDENTS AND FELLOWS IN UNIVERSITY OF CONNECTICUT SCHOOL OF
MEDICINE PROGRAMS

All medical residents/fellow physicians are fully protected by State statute from civil liability arising from any civil claim for malpractice taken in discharge of duties or within the scope of their training when the resident/fellow physician is at the University of Connecticut Health Center or at an assigned site that is not one of the affiliated hospitals for the program. Coverage is for the occurrence of an incident on those claims during the residency period and extends after the end of the residency period for incidents which occurred during the residency period. The scope of this protection is not limited in dollar amount.

By State law, when the resident/fellow physician is assigned to an affiliated hospital, coverage is from that institution. All liability coverage at affiliated hospitals is in an amount and manner equivalent to that provided by the hospital to its full time physician employees.

Anne E. Schick, MA

Anne E. Schick, MA
Director of Graduate Medical Education

2/26/01

approved: Wm.Kleinman,
Assistant Attorney General

Renewal - DR.0042827

Name	Rochelle S Bernstein
Credential	DR.0042827

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 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.

Mail all documentation to:

Colorado Medical Board, ATTN: Renewal, 1560 Broadway, Suite 1350, Denver, CO 80202

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.

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.

DR Renewal HPPP

Healthcare Professions Profiling Program ACTIVE status only:

REMINDER:

Healthcare Professions Profile Program (HPPP): All Active status licensees must maintain their Healthcare Professions Profile with current information. This profile must be updated within 30 days of any change or reportable event.

After you have completed and paid for you renewal please visit www.dora.colorado.gov/professions/hppp if you need to review and/or update your Profile. Please note: The Profile database is a separate system from our renewal system and uses a different login and password than the ones you used to renew your license.

If you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profile Program (HPPP) at: dora_dpo_hppp@state.co.us or (303) 894-5942.

After you have read the above, please click the "Next" button below.

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.0042827

Name	Rochelle S Bernstein
Credential	DR.0042827

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.

Renewal - DR.0042827

Name	Rochelle S Bernstein
Credential	DR.0042827

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
	\$428.00

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

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:

- 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

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
108 South Frontage Road West, Suite 101	Vail	Colorado	81657	(970) 926-6340
50 Buck Creek Road, Suite 200	Avon	Colorado	81620	(970) 926-6340

HPPP - MEDICAL Education and Training

Education and Training

51. School or Education Level:
University of Colorado School of Medicine

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

2000

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?
No

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
Obstetrics and Gynecology

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
Obstetrics and Gynecology

HPPP GLOBAL - CO Hospital Affiliations

Colorado Hospital Affiliations

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

Yes

HPPP GLOBAL - CO Hospital Affiliations if Yes

Colorado Hospital Affiliations

60. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
Vail Valley Medical Center	Admitting Privileges	Vail

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
Mountain Family Health Center	Other	Edwards	Colorado

HPPP GLOBAL - Business Ownership

Business Ownership

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

Yes

HPPP GLOBAL - Business Ownership if Yes

Business Ownership

64. Business Ownership:

Business Name	City	State
Colorado Mountain Medical, PC	Avon	Colorado
Medical Group Vemtures I	Avon	Colorado

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
Colorado Mountain Medical, PC	PO Box 4330	Avon	Colorado	81620	(970) 926-6340

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

DEA Registration Surrender

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

No

HPPP GLOBAL - Convictions

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

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

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

Optional Narrative

86. Optional Narrative:

HPPP GLOBAL - Attestation

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:

03/21/2017

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.