STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
Thomas J. Beckett
Program Administrator

1560 Broadway, Suite 1300
Denver, CO 80202-5140
Phone: (303) 894-7690

Department of Regulatory Agencies
Joseph A. Garcia
Executive Director
Division of Registrations
Bruce M. Douglas, Director

Roy Romer
Governor

October 20, 1993

Traci Dawn Simms, M.D.
315 Arno S.E.
Albuquerque, NM 87102

Dear Doctor:

At a meeting of the Colorado Board of Medical Examiners held on October 14, 1993, your application for Colorado medical licensure was approved.

Your license number is 33124, effective October 14, 1993.

All physician licenses expire during May of each odd numbered year, and once renewed are good for a two year period. Your license will expire May 31, 1995 - please note this date. Notice of the Renewal fee will be sent to you at the last address of record in our files. It is important to inform the Board of any changes in work or home address in order to ensure that your renewal packet will reach you in a timely manner. A second renewal notice is not required by law. It is the responsibility of each physician to remit the registration fee to this office, even though the original notice fails to reach the physician. The Board cannot assume responsibility for changes of address that do not reach its office.

Sincerely,

FOR THE BOARD OF MEDICAL EXAMINERS

Thomas J. Beckett
PROGRAM ADMINISTRATOR

TJB:lj

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690, V/TDD (303) 894-7880

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE

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.

OFFICE USE ONLY

1a. Name: Last	First	Middle	Degree	1b. Social Security Number
Simms	Traci	Dawn	M.D.	

2. Other names - Indicate if none.

3. Mailing Address: Number and Street/Rural Route, Apartment Number

315 Arno S.E.

City	State	Zip	Country
Albuquerque	New Mexico	87102	usa

4. Telephone Number: (Area Code) Day Evening

(505) 766-9299

5. Date of Birth: Mo/Day/Year Place of Birth:

[illegible] or notarized copy of your birth certificate or passport

Hardin, Montana

6. Sex
☐ Male ☒ Female

7. Have you ever filed an application in Colorado? ☐ Yes ☒ No
If yes, give date of previous application:

8. List name and address of all colleges or universities where pre-medical instruction was received. Pre-medical instruction is limited to that course work required for entrance to medical school.
Request an official copy of transcript, with seal of school affixed, to be sent directly from the school to this office.
If transcripts are not in English, send a certified English translation.

Name of school	Address and zip	Period of attendance From (Mo/Yr)	To (Mo/Yr)
University of Colorado	Boulder Colorado 80309	9/82	6/86

9. List name and address of all schools where professional medical instruction was received.
Request an original Certificate of Medical Education and official copy of transcripts, with seal of school affixed, from each school attended. Certificate and transcripts must be sent directly from the school to this office. (See Form L2)
If transcripts are not in English, send a certified English translation.

Name of school	Address and zip	Period of attendance From (Mo/Yr)	To (Mo/Yr)
University of Colorad	42[illegible] E. Ninth Ave. Denver Colorado 80262	9/86	6/90

10. Doctor of Medicine/Osteopathy Degree granted by: (Submit legible photocopy)
If degree is not in English, send a certified English translation.

Name of medical school	Address and zip	Date degree conferred
University of Colorado	4200 E. Ninth Ave. Denver Colorado 80262	6/90

License # [illegible] Date 10/17/93
Fee $ 150.00 Date 10/[illegible]/93

Org. 8/86
Revised 9/92

L1A

STATE OF COLORADO

OFFICE USE ONLY

17. Have you taken any of the following written exams: NBME, NBOME, FLEX, LMCC, USMLE, or state written exam? ☒ Yes ☐ No

If yes, request certification of scores from each examination agency, including failures, to be sent directly from examination agency to this office. (See Information sheet) Provide information below:

Exam	Location	Date	Result
National Boards	Denver; ABQ	6/88; 9/89; 3/92	

12. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian facilities?

☐ Yes ☐ No

If yes, provide information below. Request an original Certificate of Completion of ACGME/AOA-approved internship or residency training from each facility. (See Form L3)

Name of facility	Address and zip	Specialty	Period of attendance: From (Mo/Yr)	To (Mo/Yr)
University of New Mexico	2211 Lomas NE ABQ, NM 87131	OB/Gyn	6/90	Present

POSTGRAD TRAINING ☑

13a. Are you now or have you ever been licensed to practice medicine in any state, territory, district, or country? (See Form L4) ☒ Yes ☐ No Include temporary licenses and instructional permits.

If yes, provide information below:

State or country	License number	Date of issue	Dates of practice in this jurisdiction: From (Mo/Yr)	To (Mo/Yr)
New Mexico	Permission to practice	6/90	6/24/90	6/30/94

DATA ☑

13b. Are you now or have you ever practiced medicine in any state, territory, district, or country, U.S. military, U.S. Public Health, or any U.S. government agency? (See Form L6) ☒ Yes ☐ No

L4 ☐

L6 ☐

14. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been cancelled or rated at a higher premium due to past claims experience? No If yes explain on a separate sheet and provide verification of same from insurance company or state licensing board.

15. Have you ever been notified by any state, territory, district, country, U.S. government agency, state medical/osteopathic board of any complaint against you relative to the practice of medicine? This includes, but is not limited to, any allegations currently pending. ☐ Yes ☒ No

If yes, give details below:

State	Date	Charge	Disposition

REQ ☐ REC ☐

16. 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.) ☐ Yes ☒ No

If yes, give details below.

State or government agency	Date	Charge	Disposition

REQ ☐ REC ☐

17. 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:

State or government agency	Date	Reason for denial

18. Have you ever voluntarily surrendered a license to practice in the healing arts in any other state? This does not include allowing your license to lapse solely due to payment of the renewal fee.

☐ Yes ☒ No

If yes, explain on a separate sheet. Summarize below:

State	Date	Reason for surrender

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

☐ Yes ☒ No

If yes, explain on a separate sheet. Provide a copy of letter of resignation or hospital action. Summarize details below:

Name of facility	Address and zip	Date	Reason for Action

20. Do you now have, or have you ever had, a physical or mental condition which might affect your ability to practice medicine?

If yes, explain on a separate sheet. Give dates of onset, description of condition, description of treatment, name and address of treater, current status of condition.

21. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, prescription medication or alcohol?

If yes, explain on a separate sheet of paper. If treated, give name, address and zip of both facility and treater, dates of treatment, current status of condition.

22. Have you ever received a deferred prosecution, a deferred judgement, been convicted of, or pled guilty or nolo contendere to a violation of any federal, state, or local law relating to the manufacture, distribution or dispensing of controlled substances, or relating to drug abuse, including alcohol?

If yes, explain on a separate sheet. Summarize below:

Date	Court address and zip	Violation	Penalty or disposition

23. Have you ever received a deferred prosecution, a deferred judgement, been convicted of or pled guilty or nolo contendere to, any felony in any state, territory, district, the United States, or a foreign country?

☐ Yes ☒ No

If yes, give details below: Include any conviction that has been set aside, dismissed, or pardoned under the Constitution of Colorado, article IV, section 7, or under any other provision of law.

Date	Court address and zip	Violation	Penalty or disposition

24. You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado law, or state basis for exemption. See instructions in application packet.

REC REC

REC REC

REC REC

REC REC

REC REC

INS

L1C

I hereby declare under penalty of perjury under the laws of the State of Colorado that the photo of myself attached hereto, was taken on or about July 28, 19 93, my age then being 29 years; color of hair Brown; color of eyes Brown; height 5 ft. 1 in.; weight 140 lbs.; identifying marks mole on nose

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, Traci Simms, 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 that Board relative to my qualifications as a physician and my eligibility for licensure.

PLEASE BE ADVISED 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 Colorado Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

Traci Simms
Signature

8/4/93
Date

LID

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690, V/TDD (303) 894-7880

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW.

This certifies that Traci Dawn Simms
(FULL NAME OF APPLICANT)

of 1210 Harrison #9 (ADDRESS WHEN ENROLLED) enrolled in University of Colorado Medical School (NAME OF MEDICAL SCHOOL)

Denver Colorado (LOCATION) on the 25 day of August (MONTH) 19 86 (YEAR)

and was granted the following credits on enrollment:

Course of study	Institution	Date completed	Credit awarded

The undersigned further certifies that the records of this institution show that S he attended in this institution over 150 (number of weeks) of resident instruction, and that:

☒ s/he was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy, or
☐ s/he withdrew from
the above mentioned medical/osteopathic school on the 26 day of May 19 90

Signed and the college seal affixed this 6 day of August 19 92

BY Phyllis V. Compton Staff Asst II
(PRESIDENT/SECRETARY/DEAN)

NOTES TO REGISTRAR AND APPLICANT

1. Medical School Seal MUST Be Imprinted Partially on the Photograph.
2. TRANSCRIPTS OF MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE.
3. Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to the form must be original.

NOT VALID WITHOUT SCHOOL SEAL
If no school seal please indicate above next to signature of President/Secretary/Dean.

L2

COLORADO MEDICAL BOARD
AUG 12 93

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690, V/TDD (303) 894-7880

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

TO BE COMPLETED BY THE FACILITY FOR EVERY MEDICAL/OSTEOPATHIC SCHOOL GRADUATE COMPLETING POSTGRADUATE TRAINING IN THE UNITED STATES OR CANADA. DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT IS NOT ATTACHED BELOW. PLEASE TYPE OR PRINT.

This is to certify that Traci Dawn Simms
NAME OF APPLICANT

a graduate of University of Colorado Medical School
NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in University of New Mexico
NAME AND ADDRESS OF FACILITY
2211 Lomas NE
Albuquerque NM 87131

on June 24, 19 90, and satisfactorily completed such training

will complete on
on June 30, 19 94. This training consisted of _____ 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
OB/Gyn residency	4 years

WAS THIS PHYSICIAN'S PERFORMANCE COMPLETELY SATISFACTORY? PLEASE CHECK ONE
☑ YES ☐ NO
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 and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

NAME Glona E Sarto MD
PROGRAM DIRECTOR

(AFFIX INSTITUTIONAL SEAL) NOT VALID WITHOUT SEAL

Institution / Director does not have a seal

ADDRESS 2211 Lomas Blvd., NE
Albuquerque, NM 87131

PHONE NUMBER (505) 272-6883

DATE 8/5/93

SIGNATURE Glona E. Sarto MD, Ph.D.
(above)

L3

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
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Denver, Colorado 80202-5140
Phone (303) 894-7690, V/TDD (303) 894-7880

COLORADO MEDICAL BOARD
AUG 27 93

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

TO BE COMPLETED BY APPLICANT:
(Please type or print neatly.)

1. NAME (last) (first) (middle)
Simms Traci Dawn

2. ADDRESS Number and street/rural route (include apt. no. if any)
315 Arno SE

CITY: Albuquerque | STATE: New Mexico | ZIP CODE: 87102 | COUNTRY: USA

3. DATE OF BIRTH (mo/day/yr)

4. SEX: [X] Female [ ] Male

5. STATE LICENSING AGENCY: New Mexico

6. LICENSE NUMBER: Permission to practice

7. DATE OF ISSUANCE: 6/24/90

8. DATE OF EXPIRATION: 6/30/94

PLEASE BE ADVISED 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.

Traci Simms — SIGNATURE

8/3/93 — DATE

affiliated hsps.
Permission to do Residency Program at University of N.M. &

TO BE COMPLETED BY STATE LICENSING AGENCY: (Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that Traci D. Simms (NAME OF APPLICANT) who graduated from University of Colorado (NAME OF MEDICAL SCHOOL) on 05/26/90 (DATE OF GRADUATION) was granted license number Resident No. 90-R-66 on 06/22/90 (DATE LICENSE ISSUED) on the basis of National Board (FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Issued on Credentials.

I further certify that this doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE)

and obtained a general average of _____ per cent in the following subjects:

Is this license valid & current? yes Has it ever been suspended or revoked? no When does it expire? 06/30/94 (date)

According to your records, are there now or have there ever been any charges filed against this licensee? no Is there any investigation pending regarding this licensee? no IF THIS APPLICANT'S RECORD IS NOT COMPLETELY CLEAR IN REGARD TO THESE QUESTIONS, PLEASE ATTACH AN EXPLANATION.

NOT VALID WITHOUT SEAL

Imelda Gallegos, Verification Officer
TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL

(AFFIX LICENSING AGENCY SEAL)

New Mexico Board of Medical Examiners
NAME OF STATE LICENSING AGENCY

Imelda Gallegos
SIGNATURE OF AGENCY OFFICIAL

491 Old Santa Fe Trail PO Box 20001
ADDRESS

Santa Fe, N.M. 87504

08/18/93
DATE

505-827-7317
PHONE NUMBER

L4

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690, V/TDD (303) 894-7880

REPORT OF PRACTICE HISTORY

STATE OF COLORADO

INSTRUCTIONS:

1. List all of your experience in medical practice since medical school including all training programs (after internship). List all hospitals in which you held privileges for the last five years. Include temporary privileges and locum tenens positions. If locum tenens, list only the name and location of the company(ies), along with dates of service for each company. Explain gaps of one month or greater. If you have not practiced medicine, explain activities during that time.
2. Request an original letter of verification for each hospital staff, clinic, private practice, or any other medical practice and training programs (after internship) or any other medical position held during the last five years. Each letter should be written by the chief of staff or chief administrative officer (if private practice, by an associate or colleague) and must verify dates of practice, nature of practice, and privilege status. Each letter must also include an evaluation of your skill level, aptitude, ability to apply knowledge, and an assessment of your attitude and behavior toward your colleagues and patients.

	Facility Name	Address and Zip	Reference (name & title)	Date of Practice From – To Mo/Yr Mo/Yr	Nature of Practice
1.	University of New Mexico	2211 Lomas NE Albuquerque New Mexico 87131	Dr. Gloria Sarto Chairperson Dept OB/Gyn	6/90-7/94	OB/Gyn residency
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

L6

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.

Traci Simms 3/1/13
SIGNATURE DATE

Traci Simms
PRINT NAME

COLORADO BOARD OF MEDICAL EXAMINERS 1995 LICENSE RENEWAL

1977

PLEASE READ BOTH SIDES OF THIS FORM CAREFULLY BEFORE YOU BEGIN

PRINT NAME Traci Simms LICENSE NUMBER 33124

LICENSE RENEWAL QUESTIONNAIRE

Effective May 19, 1988, HB 1340 mandated that a questionnaire be mailed to, and completed by, each physician wishing to renew his/her license at the time of expiration. **COMPLETION OF THIS QUESTIONNAIRE IS NOT OPTIONAL.** You must answer yes if you have withdrawn or failed to proceed with an application for any of the items following. Each question must be answered.

		YES	NO
A)	Since you last renewed your Colorado medical license, have you:		
1.	been denied liability insurance in Colorado?	___	✓
2.	had your insurance coverage terminated by action of the insurance carrier in Colorado?	___	✓
B)	Since you last renewed your Colorado medical license, have either of the following (numbers 3&4) been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "yes" to the items below if any of these same actions are currently in progress and/or have not yet been resolved.		
3.	Medical staff membership or clinical privileges at any hospital or health care institution?	___	✓
4.	DEA registration?	___	✓
C)	Since you last renewed your Colorado license, have you:		
5.	had any felony or misdemeanor charges, or any traffic citations involving drugs or alcohol, brought against you?		
6.	illegally or excessively used any controlled substance, habit forming drug, prescription medication, or alcohol? You need not report behavior which is already known to the Colorado Board of Medical Examiners or the Colorado Physician Health Program.		
7.	engaged in any behavior or experienced any mental or physical health condition that might impair your ability to practice medicine safely and competently? You need not report behavior or conditions which are already known to the Colorado Board of Medical Examiners or the Colorado Physician Health Program.		

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, PLEASE PROVIDE THE FOLLOWING INFORMATION. IF YOU NEED TO ATTACH ANOTHER SHEET OF PAPER OR DOCUMENTS, PLEASE PUT YOUR NAME AND LICENSE NUMBER ON EACH ATTACHMENT. ANSWERING "YES" TO ANY OF THESE QUESTIONS WILL NOT AUTOMATICALLY DELAY RENEWAL OF YOUR LICENSE.

Questions 1 and 2: Indicate name and address of insurance carrier, date of action, and reasons for action. Attach copy of notification from carrier.

Questions 3 and 4: Indicate name and address of facility or organization, date of action, and reasons for action. Attach a copy of notification from agency or organization taking action.

Question 5: Indicate name and address of court of jurisdiction, violation charged, date of alleged violation, and disposition of each violation charged.

Questions 6 and 7: Provide description of condition, date of onset, dates and description of any treatment, name and address of all treatment providers, and current status of condition.

OVER

INSURANCE VERIFICATION FORM

In 1988, The Colorado General Assembly enacted a law requiring all Colorado licensed physicians to maintain certain amounts of malpractice coverage. this law became effective January 1 1990 As part of your application to renew your license to practice medicine in Colorado you must indicate how you are meeting the requirements of this law.

✓ **ACTIVE LICENSE:** I wish to renew my license via ACTIVE STATUS. I meet (or claim exemption from) the financial responsibility standards as indicated below:

____ 1. I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year.

Company: ✓ COPIC ____ Doctors Company ____ St. Paul ____ Other (Specify_____)
Policy #: _____

✓ 2. I am covered by individual commercial professional liability insurance maintained by an employer/contracting agency in accordance with the requirements noted in "1" above.

____ 3. I am engaged in city, state, or federal civilian or military service, and my practice is limited solely to those duties required by my governmental duty assignment.

____ 4. I am completely and permanently retired from the practice of medicine, including prescribing. (NOTE: You may wish to consider renewing your license via inactive status - see below).

____ 5. I do not engage in any patient care whatsoever within the state of Colorado, including prescribing. (NOTE: You may wish to consider renewing your license via inactive status - see below).

____ 6. My medical practice does not involve any patient care whatsoever (administrator, researcher, academician, non-medical endeavor, e.g.).

____ 7. I provide limited or occasional, uncompensated care to patients and I do not otherwise provide any compensated patient care whatsoever.

____ 8. I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance.
_____ Surety Bond _____ Cash Deposit or equivalent _____ Other Acceptable Security

NOTE: The Commissioner of Insurance approves alternatives for financial responsibility. Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used. The address of the Commission Office is: 1560 Broadway, Suite 850, Denver, Colorado 80202: (303) 894-7499.

__ **INACTIVE LICENSE:** I wish to renew my license via INACTIVE STATUS. (NOTE: this category is primarily intended for retired physicians and those practicing outside Colorado.) Malpractice insurance is not required for inactive license holders. I understand that I may not practice medicine, including prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active 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 medical license.

Signature of Physician	Date	License #	Phone #
[signature] MD	4/8/95	33124	(970)243-7907

After completing both sides of this form, please return it with 1) the enclosed computer renewal form, 2) renewal fee, and 3) the optional Physician Survey in the enclosed return envelope. Direct questions and other correspondence to:

THE COLORADO BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
303-894-7690

PLEASE PRINT OR TYPE

LAST NAME	FIRST NAME	M	LICENSE #	SOCIAL SECURITY #
Simms	Traci	D	33124	

BOTH SIDES OF THIS FORM MUST BE TOTALLY AND ACCURATELY COMPLETED OR IT WILL BE RETURNED TO YOU AND WILL DELAY YOUR RENEWAL.

Read both sides carefully before you begin. Make a copy for your records.

COLORADO BOARD OF MEDICAL EXAMINERS 1997 LICENSE RENEWAL QUESTIONNAIRE

The Colorado Medical Practice Act mandates that a questionnaire be mailed to, and completed by, each physician wishing to renew his/her license at the time of expiration. **COMPLETION OF THIS QUESTIONNAIRE IS NOT OPTIONAL**. Each question must be answered. Answering "yes" to any of these questions **will not** automatically delay renewal of your license.

	YES	NO
A) Since you last renewed your Colorado medical license, have you:		
1. had any adverse action taken against you by any licensing agency in another state or country, any peer review body, any health care institution, any professional or medical society or association, any governmental agency, any law enforcement agency, or any court?	☐	☑
2. surrendered a license or other authorization to practice medicine in another state or jurisdiction or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?	☐	☑
3. had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? (Note: Please include any payments you have personally made.)	☐	☑
4. been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier?	☐	☑
B) Since you last renewed your Colorado medical license, have either of the following been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "yes" to the items below if any of these same actions are currently pending. (Note: You must answer yes if you have withdrawn or failed to proceed with an application for any of these items.)		
5. Medical staff membership or clinical privileges at any hospital or health care institution?	☐	☑
6. DEA registration?	☐	☑
C) Since you last renewed your Colorado license, have you:		
7. had any felony or misdemeanor charges, or any traffic citations involving drugs or alcohol, brought against you?		
8. illegally or excessively used any controlled substance, habit forming drug, prescription medication, or alcohol? You need not report behavior which is already known to the Colorado Board of Medical Examiners or the Colorado Physician Health Program		
9. engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine safely and competently? You need not report behavior or conditions which are already known to the Colorado Board of Medical Examiners or the Colorado Physician Health Program		

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, PLEASE PROVIDE THE FOLLOWING INFORMATION. IF YOU NEED TO ATTACH ANOTHER SHEET OF PAPER OR DOCUMENTS, PLEASE PUT YOUR NAME AND LICENSE NUMBER ON EACH ATTACHMENT.

Questions 1 and 2: Indicate name and address of the entity taking the action or investigating conduct/allegations, the date of the action and specify conduct/allegations upon which the action or investigation was initiated. Please include documentation of any charges and/or final action.

Questions 3 and 4: Indicate name and address of insurance carrier, reasons for action, and date of alleged conduct. Attach copy of notification from carrier.

Questions 5 and 6: Indicate name and address of facility or organization, date of action, and specific conduct/allegations upon which action was taken. Attach a copy of notification from agency or organization taking action.

Question 7: Indicate name and address of court of jurisdiction, violation charged, date of alleged violation, and disposition of each violation charged.

Questions 8 and 9: Provide description of condition, date of onset, dates and summary of any treatment, name and address of all treatment providers, and current status of condition.

– OVER –

1997 RENEWAL INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility.

☐ **I WISH TO CHANGE FROM INACTIVE TO ACTIVE STATUS: FEE - $195.** You must complete a different form. Please call the Board Office at (303) 894-7719 to request a Reactivation Form.

☑ **ACTIVE LICENSE: FEE - $195.** I wish to renew my license via ACTIVE STATUS. I meet (or claim exemption from) the financial responsibility standards as indicated below: **You must check at least one.**

☑ 1. I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year.

Company: COPIC ☑ **Doctors Company** ☐ **St. Paul** ☐ **Other (Specify_____)**

NOTE: Please supply your insurance policy number: _____

☐ 2. I am covered by individual commercial professional liability insurance maintained by an employer/contracting agency in accordance with the requirements noted in "1" above.

☐ 3. I am a federal civilian or military physician whose practice is limited solely to that required by my federal or military agency.

☐ 4. I am a public employee whose practice is limited solely to that covered by the Colorado Governmental Immunity Act.

☐ 5. I do not engage in any patient care whatsoever within the state of Colorado, including prescribing. I am, however, engaged in active medical practice in another state or foreign jurisdiction. (NOTE: You may wish to consider renewing your license via inactive status - see below).

☐ 6. My medical practice does not involve any patient care whatsoever (e.g., administrator, researcher, academician, non-medical endeavor. (NOTE: You may wish to consider renewing your license via inactive status - see below.)

☐ 7. I provide limited or occasional, uncompensated care to patients and I do not otherwise provide any compensated patient care whatsoever.

☐ 8. I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance:

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

NOTE: The Commissioner of Insurance approves alternatives for financial responsibility. Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used. The address of the Commission Office is: 1560 Broadway, Suite 850, Denver, Colorado 80202; (303) 894-7499.

☐ **INACTIVE LICENSE: FEE: $100.** I wish to renew my license via INACTIVE STATUS. (NOTE: this category is primarily intended for retired physicians and those practicing outside Colorado.) Malpractice insurance is not required for inactive license holders. **I understand that I may not practice medicine, including 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 $95.00. I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.**

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

Signature of Physician	Date	Phone #	Fax ##
[signature] MD	3/20/96	970 243-7908	970-245-0656

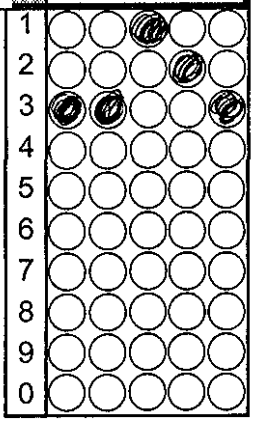
After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee, and 3) the Physician Survey (optional) in the enclosed return envelope. Direct questions to: **(303) 894-7690 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver, CO 80202-5140**

9/24/99 - Score Wattached. See Case # 5199020580, PD 5/10

COLORADO BOARD OF MEDICAL EXAMINERS 1999 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	M	SOCIAL SECURITY #	COLORADO 5 DIGIT LICENSE #
Simms	Traci	D		33124

Instructions Print or type name and Social Security Number and license number above Fill in the circle that corresponds to each number of your license number.



BOTH SIDES OF THIS FORM MUST BE TOTALLY AND ACCURATELY COMPLETED OR IT WILL BE RETURNED TO YOU AND WILL DELAY YOUR RENEWAL.
Read both sides carefully before you begin. **Make a copy for your records.**

The Colorado Medical Practice Act mandates that a questionnaire be mailed to, and completed by, each physician wishing to renew his/her license at the time of expiration **COMPLETION OF THIS QUESTIONNAIRE IS NOT OPTIONAL** Each question must be answered Answering "yes" to any of these questions **will not** automatically delay renewal of your license

	YES	NO
A) Since you last renewed your Colorado medical license, have you		
1 had any adverse action taken against you by any licensing agency in another state or country, any peer review body, any health care institution, any professional or medical society or association, any governmental agency, any law enforcement agency, or any court?	☐	☑
2 surrendered a license or other authorization to practice medicine in another state or jurisdiction or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?	☐	☑
3 had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? (Note Please include any payments you have personally made)	☑ See above	☐
4 been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier?	☐	☑
B) Since you last renewed your Colorado medical license, have either of the following been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "yes" to the items below if any of these same actions are currently pending (Note You must answer yes if you have withdrawn or failed to proceed with an application for any of these items)		
5 Medical staff membership or clinical privileges at any hospital or health care institution?	☐	☑
6. DEA registration?	☐	☑
C) Since you last renewed your Colorado license, have you		
7 had any felony or misdemeanor charges, or any traffic citations involving drugs or alcohol, brought against you?		
8 illegally or excessively used any controlled substance, habit forming drug, prescription medication, or alcohol? You may answer NO if the behavior is already known to the Colorado Physician Health Program		
9 engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine safely and competently? You may answer NO if the behavior or conditions are already known to the Colorado Physician Health Program		

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, PLEASE PROVIDE THE FOLLOWING INFORMATION. IF YOU NEED TO ATTACH ANOTHER SHEET OF PAPER OR DOCUMENTS, PLEASE PUT YOUR NAME AND LICENSE NUMBER ON EACH ATTACHMENT.

Questions 1 and 2 Indicate name and address of the entity taking the action or investigating conduct/allegations, the date of the action and specify conduct/allegations upon which the action or investigation was initiated Please include documentation of any charges and/or final action

Questions 3 and 4 Indicate name and address of insurance carrier, reasons for action, and date of alleged conduct Send copy of final action, amount of settlement, copy of report from National Practitioner Data Bank and a clinical narrative of the case, including patient's name

Questions 4 Attach copy of notification from insurance carrier

Questions 5 and 6 Indicate name and address of facility or organization, date of action, and specific conduct/allegations upon which action was taken Attach a copy of notification from agency or organization taking action

Question 7 Indicate name and address of court of jurisdiction, violation charged, date of alleged violation, and a copy of the final disposition of each violation charged.

Questions 8 and 9 Provide description of condition, date of onset, dates and summary of any treatment, name and address of all treatment providers, and current status of condition

– OVER –

1999 RENEWAL INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility.

☐ **I WISH TO CHANGE FROM INACTIVE TO ACTIVE STATUS: FEE - $305.** You must complete a different form Please call the Board Office at (303) 894-7719 to request a Reactivation Form

☑ **ACTIVE LICENSE: FEE - $305.** I wish to renew my license via ACTIVE STATUS I meet (or claim exemption from) the financial responsibility standards as indicated below **You must check at least one.**

☑ 1 I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year.

Company: COPIC ☑ **Doctors Company** ☐ **St. Paul** ☐ **Other (Specify_____)**

NOTE: Please supply your insurance policy number: CRF940616WS

☐ 2 I am covered by individual commercial professional liability insurance maintained by an employer/contracting agency in accordance with the requirements noted in "1" above.

☐ 3 I am a federal civilian or military physician whose practice is limited solely to that required by my federal or military agency

☐ 4 I am a public employee whose practice is limited solely to that covered by the Colorado Governmental Immunity Act

☐ 5 I do not engage in any patient care whatsoever within the state of Colorado, including prescribing I am, however, engaged in active medical practice in another state or foreign jurisdiction (NOTE You may wish to consider renewing your license via inactive status - see below)

☐ 6 My medical practice does not involve any patient care whatsoever (e g , administrator, researcher, academician, non-medical endeavor (NOTE You may wish to consider renewing your license via inactive status - see below)

☐ 7 I provide limited or occasional, uncompensated care to patients and I do not otherwise provide any compensated patient care whatsoever

☐ 8 I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance (Must have approval from the Colorado Commissioner of Insurance See note below).

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

NOTE The Commissioner of Insurance approves alternatives for financial responsibility Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used The address of the Commission Office is 1560 Broadway, Suite 850, Denver, Colorado 80202 (303) 894-7499.

MAKE CHECKS PAYABLE TO: COLORADO BOARD OF MEDICAL EXAMINERS

☐ **INACTIVE LICENSE FEE - $150** I wish to renew my license via INACTIVE STATUS. (NOTE this category is primarily intended for retired physicians and those practicing outside Colorado) Malpractice insurance is not required for inactive license holders **I understand that I may not practice medicine, including 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 $155.00. I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.**

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

Signature of Physician	Date	Phone #	Fax ##
[signature]	4/19/99	970-245-1168	970-242-4299

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee, and 3) the Physician Survey (optional) in the enclosed return envelope Direct questions to **(303) 894-7719 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver, CO 80202-5140**

COLORADO BOARD OF MEDICAL EXAMINERS
2001 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #	LICENSE #
Simms	Traci	D		33124

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

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

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

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

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

1 had any adverse action taken against you by any licensing agency in another state or country, any peer review body, health care facility, professional or medical society or association, governmental agency, law enforcement agency, or court of law?
☐ YES ☑ NO

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

2 surrendered a license or other authorization to practice medicine in another state or jurisdiction, or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?
☐ YES ☑ NO

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

3 had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? NOTE Include any payments you have made personally ☐ YES ☑ NO

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

4 been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier? ☐ YES ☑ NO

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

5 had any felony or misdemeanor charges of any kind brought against you? Had any traffic citations involving drugs or alcohol, brought against you? Regardless of the case disposition, you **must** answer yes if you have been charged
YES NO

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

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

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

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

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

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

1 Medical staff membership or clinical privileges at any hospital or healthcare facility? ☐ YES ☑ NO

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

2 DEA registration? ☐ YES ☑ NO

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

HAVE YOU PREVIOUSLY REPORTED ANY OF THE ABOVE MATTERS TO THE BOARD? ☐ **YES** ☑ **NO**
IF YES, PROVIDE DOCUMENTATION IN SUPPORT OF YOUR RESPONSE. IF APPLICABLE, PROVIDE A COPY OF THE FINAL DISPOSITION FROM THE BOARD.

2001 LICENSE RENEWAL QUESTIONNAIRE AND INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility Please be advised, you CANNOT use this renewal form to change your status from FROM INACTIVE TO ACTIVE You must complete a reactivation application to reactivate your license Please call the Board Office at (303) 894-7690 to request a reactivation application This is a process separate and independent from the renewal process

☐ ACTIVE LICENSE FEE - $315 I wish to renew my license in ACTIVE STATUS I meet (or claim exemption from) the financial responsibility standards as indicated below· You **must check at least one.**

- ☐ I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year

  ☑ COPIC ☐ Doctors Company ☐ St Paul ☐ Other (Specify)_____

  NOTE Please supply your insurance policy number CRF 940614
- ☐ I am a federal civilian or military physician whose practice is limited solely to that required by my federal/military agency
- ☐ I am a physician who is not engaged in the practice of medicine
- ☐ I am a physician who is covered by individual commercial professional liability coverage (or an alternative which complies with Section 13-64-301(1)(c), (d) or (e)) maintained by an employer/contracting agency in the amounts set forth above
- ☐ I am a physician who provides uncompensated health care to patients, or who does not otherwise engage in any compensated patient care in Colorado
- ☐ I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance (Must have approval from the Colorado Commissioner of Insurance See note below)

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

NOTE The Commissioner of Insurance approves alternatives for financial responsibility Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used The address of the Commission Office is 1560 Broadway, Suite 850, Denver, Colorado 80202 (303) 894-7499

☐ INACTIVE LICENSE FEE - $160 I wish to renew my license in INACTIVE STATUS Malpractice insurance is not required for inactive license holders **I understand that I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license.** I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations

MAKE CHECKS PAYABLE TO· COLORADO BOARD OF MEDICAL EXAMINERS

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

T Simms 4/9/01

Signature of Physician **Date**

Traci Simms 33124

Print name of physician **(printed name and license number must be legible to process this form)** **License #**

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee and 3) the Physician Survey (optional) in the enclosed return envelope Direct questions to (303) 894-7690 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver CO 80202-5140

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
Susan Miller
Program Administrator

1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone: (303) 894-7690
Fax: (303) 894-7692
V/TDD (303) 894-7880
http://www.dora.state.co.us/medical/

Department of Regulatory Agencies
M. Michael Cooke
Executive Director

Division of Registrations
Bruce M. Douglas, Director

Bill Owens
Governor

VIA CERTIFIED MAIL
January 13, 2000
Case # 5199020580

Traci D. Simms, M.D.
% Women's Health Care
2525 N. 8th St., Ste. 202
Grand Junction, CO 81201

Dear Dr. Simms:

Inquiry Panel B of the Colorado Board of Medical Examiners has concluded its inquiry regarding your role in the care and treatment of patient D.B. and her infant S.M. The Panel determined that the matter may not warrant the commencement of formal pro9cededings against your license to practice medicine. However, the Panel voted to administer disciplinary action to you in the form of this letter of admonition.

Board records reflect that prior to your involvement, 15 year-old obstetrical patient D.B. had received poor prenatal care and had a questionable date of conception. A previous ultrasound performed in Missouri was consistent with 42 weeks. After D.B. presented to you, you appropriately offered amniocentesis, which the patient and her father declined. You then appropriately decided to proceed as if this was a post-date pregnancy and ordered a non-stress test, which was non-reactive, and a biophysical profile, which was scored at 6 out of 8. You then properly recommended that D.B. be admitted at St. Mary's Hospital, which had a level II nursery. However, the patient and her father instead chose to proceed to Community Hospital for induction of labor.

At Community Hospital, pitocin induction was performed. The patient made slow but gradual progress throughout the labor course. At the time that D.B. reached complete dilatation and began pushing, fetal bradycardia occurred, and an internal scalp electrode was placed, confirming this bradycardia. You attempted multiple vacuum extractions and then a forceps delivery. After those attempts were unsuccessful, you performed an emergency cesarean section. The infant had apgars of 0, 4, and 4.

There have been medical experts who determined that your care of D.B. met the applicable standards of care and other medical experts who determined that it did not meet the applicable standards of care.

The Panel has found that your labor management of D.B. during the second stage of labor constituted unprofessional conduct. Specifically, the Panel found that you should have immediately called the cesarean section when the first vacuum attempt did not result in delivery or a reassuring fetal heart pattern. Instead, there was a significant delay prior to deciding to proceed with a Cesarean section. There was also delayed ability of the operating room staff to respond due to the rural setting. Your delay in adequately recognizing fetal distress was one of the several factors that contributed to the infant being significantly neurologically compromised.

By this letter, the Panel hereby admonishes you and cautions you that complaints disclosing any repetition of such practice may lead to the commencement of formal disciplinary proceedings against your license to practice medicine, wherein this letter of admonition may be entered into evidence as aggravation. You have agreed to accept this letter of admonition.

You are advised that you have the right within twenty (20) days after receipt of this letter to make written request that formal disciplinary proceedings be initiated against you to adjudicate the propriety of the conduct upon which this letter of admonition is based. If such request is timely made, this letter of admonition will be deemed vacated, and the matter will be processed by means of a formal complaint and hearing, in accordance with the provisions of the Medical Practice Act governing the discipline of licensed physicians.

Very truly yours,

FOR THE BOARD OF MEDICAL EXAMINERS
INQUIRY PANEL B

Pamela L. Kimbrough, M.D.
Chair

PK/de

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS

STATE OF COLORADO

CASE NUMBER 2004-003627-B

STIPULATION AND FINAL AGENCY ORDER

IN THE MATTER OF THE DISCIPLINARY PROCEEDING REGARDING THE LICENSE TO PRACTICE MEDICINE IN THE STATE OF COLORADO OF TRACI D. SIMMS M.D., LICENSE NUMBER 33124,

Respondent.

IT IS HEREBY STIPULATED and agreed by and between Inquiry Panel B ("Panel") of the Colorado State Board of Medical Examiners ("Board") and Traci D. Simms, M.D., ("Respondent") as follows:

JURISDICTION AND CASE HISTORY

1. Respondent was licensed to practice medicine in the state of Colorado on October 19, 1993 and was issued license number 33124, which Respondent has held continuously since that date.

2. The Panel and the Board have jurisdiction over Respondent and over the subject matter of this proceeding.

3. On November 19, 2004, the Panel reviewed case number 2004-003627-B. The Panel thereupon referred the matter to the Attorney General pursuant to § 12-36-118(4)(c)(IV), C.R.S.

4. It is the intent of the parties and the purpose of this Stipulation and Final Agency Order ("Order") to provide for a settlement of all matters set forth in case number 2004-003627-B without the necessity of holding a formal disciplinary hearing. This Order constitutes the entire agreement between the parties, and there are no other agreements or promises, written or oral, which modify, interpret, construe or affect this Order.

5. Respondent understands that:

a. Respondent has the right to be represented by an attorney of the Respondent's choice, and Respondent is so represented in this matter;

b. Respondent has the right to a formal disciplinary hearing pursuant to § 12-36-118(5), C.R.S.;

c. By entering into this Order, Respondent is knowingly and voluntarily giving up the right to a hearing, admits the facts contained in this Order, and relieves the Panel of its burden of proving such facts; and

d. Respondent is knowingly and voluntarily giving up the right to present a defense by oral and documentary evidence and to cross-examine witnesses who would testify on behalf of the Panel.

6. Respondent specifically admits and agrees that:

a. Respondent is a physician specializing in obstetrics and gynecology who followed patient S.O. for prenatal care from the 26th week of S.O's pregnancy.

b. S.O. was admitted for induction and delivery at 41 2/7 weeks.

c. S.O. had slow but adequate progress to complete dilation with a delivery lasting approximately 2 ½ hours to include silastic vacuum extraction.

d. During the early part of labor, the fetal heart rate tracing supported fetal well being.

e. During the later part of the labor, the fetal heart tracing showed repetitive variable decelerations with pushing.

f. The infant required resuscitation after delivery and developed multiple organ failure.

g. The infant died four days after birth following the withdrawal of life support.

7. It is alleged that during the later part of delivery, the fetal heart tracings were non-reassuring, and that Respondent did not document an adequate assessment of the condition of the fetus. This allegation is one of unprofessional conduct as defined in § 12-36-117(1)(p), C.R.S.

8. Based upon the above, and with the consent of the Respondent, the Panel is authorized by § 12-36-118(5)(g)(III), C.R.S. to order probation and such conditions upon Respondent's practice that it deems appropriate.

PROBATIONARY TERMS

9. Respondent's license to practice medicine is hereby placed on probation for a period of five years commencing on the effective day of the Order. All terms of probation shall be effective throughout the probationary period and shall constitute terms of this Order.

10. The probationary period may be tolled and extended beyond five years in the event that a practice monitor is not providing timely monitoring of Respondent's practice as set forth below in this Order.

CPEP EDUCATION PROGRAM

11. Within 30 days of the effective date of this Order, Respondent shall contact the Center for Personalized Education for Physicians ("CPEP") to schedule an assessment ("CPEP Assessment"). Respondent shall complete the CPEP Assessment and sign the written assessment within 120 days of the effective date of this Order.

12. The CPEP Assessment will determine whether CPEP recommends that Respondent undergo any education plan or other remedial education or training program. Hereinafter, the term "Education Program" shall refer to any education plan or other remedial education or training program recommended by CPEP.

13. If the CPEP Assessment indicates Respondent should undergo an Education Program, Respondent shall enroll in the recommended Education Program within 180 days of the effective date of this Order. If the CPEP Assessment indicates that Respondent need not undergo any Education Program, then Respondent shall be deemed to have satisfied fully this condition, and shall have no further responsibilities with regard to CPEP.

14. Respondent shall timely and successfully complete any recommended Education Program, including any post-education evaluation recommended by CPEP ("Post-Education Evaluation"), within the time set out by CPEP unless the Panel determines in its discretion that a different time frame is appropriate.

15. Respondent shall cause CPEP to send a copy of the assessment and any recommended Education Program to the Panel. Respondent shall sign any and all releases necessary to allow CPEP to communicate with the Panel, and Respondent shall not revoke such releases prior to successful completion of any recommended Education Program, including successful completion of the Post-Education Evaluation. Any failure to execute such a release or any premature revocation of such a release shall constitute a violation of this Order.

16. All instructions issued by CPEP shall constitute terms of this Order. Respondent shall comply with all CPEP instructions within the time periods set out by CPEP and/or the Panel.

17. Respondent shall complete successfully a Post-Education Evaluation within six months of successful completion of the activities recommended within the Education Program.

18. In order to complete successfully the Post-Education Evaluation, Respondent's performance on the above-referenced Post-Education Evaluation must, in the opinion of CPEP, demonstrate that Respondent has successfully completed the objectives of the Education Program and has integrated this learning into Respondent's medical practice and into Respondent's clinical thinking.

19. Respondent shall provide the Panel with written proof from CPEP upon successful completion of the recommended Education Program, including successful completion

of the Post-Education Evaluation as defined above. The CPEP Assessment, Education Program, Post-Education Evaluation and all associated CPEP documents are confidential pursuant to the provisions of C.R.S. § 12-36-118(10).

PRACTICE MONITORING

20. During the probationary period, a "practice monitor" shall monitor Respondent's medical practice. Within 30 days of the effective date of this Order, Respondent shall nominate, in writing, a proposed practice monitor for the Panel's approval. The nominee shall be a physician licensed by the Board and currently practicing medicine in Colorado. The nominee shall have no financial interest in Respondent's practice of medicine. The nominee must be knowledgeable in Respondent's area of practice. If Respondent is board certified in an area of practice, it is preferred, but not required, that the nominee be board certified by that same board. If the Respondent has privileges at hospitals, it is preferred, but not required, that the nominee have privileges at as many of those same hospitals as possible. The Board shall not have disciplined the nominee.

21. Respondent's nomination for practice monitor shall set forth how the nominee meets the above criteria. With the written nomination, Respondent shall submit a letter signed by the nominee as well as a current *curriculum vitae* of the nominee. The letter from the nominee shall contain a statement from the nominee indicating that the nominee has read this Order and understands and agrees to perform the obligations set forth herein. The nominee must also state that the nominee can be fair and impartial in the review of the Respondent's practice.

22. Upon approval by the Panel, the practice monitor shall perform the following:

a. Each month, the practice monitor shall visit all the offices at which Respondent practices medicine and review at least five charts maintained by Respondent. The practice monitor shall make reasonable efforts to insure that Respondent has no notice of which charts will be selected for review. The practice monitor is authorized to review such other medical records maintained by Respondent as the practice monitor deems appropriate.

b. Each month, the practice monitor shall review at least five hospital charts of patients whom Respondent has admitted to, evaluated at, or treated at hospitals. If Respondent has admitted, evaluated, or treated fewer than five patients, the practice monitor shall review all the patients so admitted, evaluated, or treated, if any. The practice monitor shall make reasonable efforts to insure that Respondent has no notice of which charts will be selected for review. The practice monitor is authorized to review such other hospital charts as the practice monitor deems appropriate.

c. The practice monitor shall submit quarterly written reports to the Panel.

d. The practice monitor's reports shall include the following:

i. a description of each of the cases reviewed; and

ii. as to each case reviewed, the practice monitor's opinion whether Respondent is practicing medicine in accordance with generally accepted standards of medical practice.

23. If at any time the practice monitor believes Respondent is not in compliance with this Order, is unable to practice with skill and safety to patients, or has otherwise committed unprofessional conduct as defined in § 12-36-117(1), C.R.S., the practice monitor shall immediately inform the Panel.

24. It is the responsibility of Respondent to assure that the practice monitor's reports are timely and complete. Failure of the practice monitor to perform the duties set forth above may result in a notice from Board staff requiring the nomination of a new practice monitor. Upon such notification, Respondent shall nominate a new practice monitor according to the procedure set forth above. Respondent shall nominate the new monitor within 30 days of such notice. Failure to nominate a new monitor within 30 days of such notification shall constitute a violation of this Order.

TOLLING OF THE PROBATIONARY PERIOD WHEN PRACTICE MONITORING IS NOT IN EFFECT

25. If a practice monitor nominated by Respondent and approved by the Panel does not commence practice monitoring within three months of the effective date of the Order, the period of probation shall be tolled for the time the Order is in effect and Respondent's practice is not being monitored by the practice monitor. Additionally if the Respondent is required to nominate a new practice monitor, the period of probation shall be tolled for any period of time during which a practice monitor is not monitoring Respondent's practice.

26. Respondent must comply with all other terms of the Order and all other terms of probation. Unless otherwise specified, all terms of the Order and all terms of probation shall remain in effect, regardless of whether the probationary period has been tolled, from the effective date of this Order until the date probation is terminated.

EARLY TERMINATION FROM PRACTICE MONITORING and PROBATION

27. After successful completion of the CPEP education plan or other remedial training or educational program, including any final evaluations, but no sooner than after successful completion of three years of probation, Respondent may petition the Panel for early termination of practice monitoring and probation. The parties agree that the Panel's decision regarding such a petition shall be made at the sole discretion of the Panel. Respondent is waiving the right to appeal the Panel decision on this issue.

OUT OF STATE PRACTICE

28. Respondent may wish to leave Colorado and practice in another state. At any time, whether to practice out of state or for any other reason, Respondent may request that the Board place Respondent's license on inactive status as set forth in § 12-36-137, C.R.S. Upon the approval

of such request, Respondent may cease to comply with the terms of this Order. Failure to comply with this Order while inactive shall not constitute a violation of this Order. While inactive, Respondent shall not perform any act in the state of Colorado that constitutes the practice of medicine, nor shall Respondent perform any act in any other location pursuant to the authority of a license to practice medicine granted by the state of Colorado. Unless Respondent's license is inactive, Respondent must comply with all provisions of this Order, irrespective of Respondent's location. The probationary period will be tolled for any period of time Respondent's license is inactive.

29. Respondent may resume the active practice of medicine at any time as set forth in § 12-36-137(5), C.R.S. With such request, Respondent shall nominate a practice monitor as provided above and, unless Respondent has already provided proof of successful completion of all CPEP requirements under this Order, Respondent must provide a report by CPEP regarding the status of Respondent's progress with CPEP. Respondent shall be permitted to resume the active practice of medicine only after approval of the practice monitor and review and, if applicable, approval of CPEP's report.

TERMINATION OF PROBATION

30. Upon the expiration of the probationary period, Respondent may request restoration of Respondent's license to unrestricted status. If Respondent has complied with the terms of probation, and if Respondent's probationary period has not been tolled, such release shall be granted by the Panel in the form of written notice.

TERMS OF THE ORDER

31. The terms of this Order were mutually negotiated and determined.

32. Both parties acknowledge that they understand the legal consequences of this Order, both parties enter into this Order voluntarily, and both parties agree that no term or condition of this Order is unconscionable.

33. This Order shall be effective upon approval by the Panel and signature by a Panel member. Respondent acknowledges that the Panel may choose not to accept the terms of this Order and that if the Order is not approved by the Panel and signed by a Panel member, it is void.

34. All costs and expenses incurred by Respondent to comply with this Order shall be the sole responsibility of Respondent, and shall in no way be the obligation of the Board or Panel.

35. Respondent shall obey all state and federal laws during the probationary period.

36. So that the Board may notify hospitals of this agreement pursuant to § 12-36-118(13), C.R.S., Respondent presently holds privileges at the following hospitals:

_____St. Mary's Hospital, Grand Junction_____

_____Community Hospital, Grand Junction_____

_____Veteran's Hospital, Grand Junction_____

37. This Order and all its terms shall have the same force and effect as an order entered after a formal hearing pursuant to § 12-36-118(5)(g)(III), C.R.S., except that it may not be appealed. Failure to comply with the terms of this Order may be sanctioned by the Inquiry Panel as set forth in § 12-36-118(5)(g)(IV), C.R.S. This Order and all its terms also constitute a valid board order for purposes of § 12-36-117(1)(u), C.R.S. In addition to any other sanction that may be imposed, failure to comply with the terms of this Order shall toll the probationary period.

38. This Order shall be admissible as evidence at any future hearing before the Board.

39. During the pendency of any action arising out of this Order, the obligations of the parties shall be deemed to be in full force and effect and shall not be tolled.

40. Upon becoming effective, this Order shall be open to public inspection and publicized pursuant to the Board's standard policies and procedures. Additionally, this Order shall be reported the Federation of State Medical Boards, the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank and as otherwise required by law.

Traci D. Simms, M.D.

The foregoing was acknowledged before me this 15 day of July, 2005 by Traci D. Simms, M.D.

Lynda Fry
NOTARY PUBLIC

LYNDA FRY NOTARY PUBLIC STATE OF COLORADO
My Commission Expires 03/23/2009

Commission expiration date

THE FOREGOING Stipulation and Final Agency Order is approved and effective this 18th day of August, 2005.

FOR THE COLORADO STATE BOARD OF MEDICAL EXAMINERS

INQUIRY PANEL B

Paul L. Lyons D.O.

APPROVED AS TO FORM:

FOR THE RESPONDENT

ROBERT SPENCER, 8801
Montgomery Little & McGrew
The Quadrant
5445 DTC Parkway
Suite 800
Greenwood Village, Colorado 80111
Telephone: (303) 773-8100
FAX: (303) 220-0412

FOR THE BOARD OF MEDICAL EXAMINERS

JOHN W. SUTHERS
Attorney General

Ilene Wolf Moore

ILENE WOLF MOORE, 28898*
Assistant Attorney General
Business and Licensing Section
Attorneys for the Colorado Board of Medical Examiners , Inquiry Panel B
1525 Sherman Street, 5th Floor
Denver, Colorado 80203
Telephone: (303) 866-5275
FAX: (303) 866-5395
*Counsel of Record