

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 First Middle Degree				1b. Social Security Number	
BURTON CAITLIN CADENA MD					
2. Other names (i.e. maiden name)- indicate if none.			What is your speciality(s)		
CAITLIN MARIA CADENA			OB/GYN		
3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE: Address provided is, by law, public information.)					
<input checked="" type="checkbox"/> Home <input type="checkbox"/> Business 10104 NW ENGLEMAN ST					
City		State		Zip	Country
PORTLAND		OR		97229	USA
e-mail address: GIOBGYN@EXCITE.COM					
4. Telephone Number: (Area Code) Day Evening			5. Date of Birth: Mo/Day/Year		Place of Birth
503-544-7218 503-203-6711					RENO, NV
6. Sex		7. Have you ever filed an application in Colorado?			
Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, give date of previous application			
8.a. List name/address of the school where medical degree was received. Request an original L2 Form (Certificate of Medical Education - Certificate must be sent directly from the school to this office.)					
Name of School		Address and Zip		Period of Attendance	
				From (Mo/Yr)	To (Mo/Yr)
UNIV. OF WASHINGTON		PO BOX 356340, SEATTLE WA 98195		9/93	6/97
8 b. If this is an international medical school, please provide the country where the school is physically located: N/A					
9. List name of licensing exam(s): ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam. Request certification of scores from examining agency be sent directly to this office.					
Exam	Location		Date	Result	
USMLE STEP 1	SEATTLE, WA		6/95		
USMLE STEP 2	SEATTLE, WA		8/96		
USMLE STEP 3	ROCHESTER, NY		5/99		
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)
STRONG MEMORIAL HOSP.		OBSTETRICS & GYNECOLOGY (INTERNSHIP & RESIDENCY)		7/97	7/01
11. Are you Board Certified by either the American Board of Medical Specialties or the American Osteopathic Association? <input checked="" type="checkbox"/> Yes If Yes, list certification information. # 9004116 <input type="checkbox"/> No AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY 11/93					
Official Use Only		License #		Date	
		43725		6/28/05	
Revised 10/99		Fee \$		Date:	

L1A

6/28/05
KD

CR# 2061
4/18/05

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
OREGON ✓	MD22947	4/13/01	12/31/2005
NEW YORK ✓	219-018-1	8/29/00	7/31/02

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

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

State	Date	Charge	Disposition

14. Has any healing arts license which you now hold or have ever held been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any healthcare facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question.

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

State	Date	Charge	Disposition

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

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

Agency	Date	Reason

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

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

Agency	Date	Reason for denial

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

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

Agency	Date	Reason

18. Have either your medical staff membership or clinical privileges at any hospital or healthcare facility or your DEA registration been voluntarily or involuntarily reduced, limited, placed on probation, not renewed or relinquished or have either of the following been denied, revoked or suspended? You must answer "yes" if any of these actions are currently pending. You must answer "yes" if you have withdrawn or failed to proceed with an application for these items.

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

No

Name of facility	Date	Reason for action
LEGACY HOSPITALS	4/05	VOLUNTARY RELINQUISHMENT - MOVING TO CO
PROVIDENCE HOSPITALS	'03, '04	PRACTICE CHANGES

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

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

No

Date	Court	Violation	Penalty or disposition

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

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

No

Date	Name and address of Insurance Company	Reason for Action

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

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

No

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

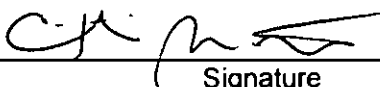
I understand that if my application does not have any issues which require Board review my application will be administratively approved as soon as it becomes complete unless I indicate otherwise below.

- Process my application for review now.
 Process my application for review on or after (list month and year): _____

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

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

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

 4/10/05
Signature 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 Department of Regulatory Agencies

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

Division of Registrations



REPORT OF PRACTICE HISTORY

Facility Name	Address and Zip	Reference (name and title)	Dates of Practice From-To	Nature of Practice
1. UNIVERSITY OF ROCHESTER STRONG MEMORIAL HOSP	DEPT. OF OB/GYN, BOX 668 601 ELMWOOD AVE ROCHESTER, NY 14642	RUTH ANNE QUEENAN, MD PROGRAM DIRECTOR	7/97-7/01	INTERNSHIP & RESIDENCY
2. PORTLAND OBSTETRICS & GYNECOLOGY ASSOC, LLC	1130 NW 22ND AVE, #120 PORTLAND, OR 97229	TIM DOOLEY, MD PRESIDENT	8/01-2/03	PRIVATE PRACTICE
3. DOWNTOWN WOMENS CENTER	511 SW 10TH, #905 PORTLAND, OR 97205	JANE WHITE, RN OWNER	6/02-PRESENT	OUTPATIENT CLINIC
4. LEACH HOSPITAL EMANUEL & GOOD SAM	2801 N. GARDENBEN PORTLAND, OR 97227	JOSEPH PULITO, MD MEDICAL STAFF PRESIDENT	10/01- 3/05	HOSPITAL PRIVILEGES -ACTIVE
5. ST. VINCENTS HOSPITAL	9205 SW BARNES RD PORTLAND, OR 97225	FREDERICK WALLER, MD MEDICAL STAFF PRESIDENT	9/01-5/03	HOSPITAL PRIVILEGES COURTESY
6. EVERY WOMANS HEALTH	501 N. GRAHAM, #445 PORTLAND, OR 97227	BRENDA KEHOE, MD SENIOR PARTNER	3/03-5/03	PRIVATE PRACTICE
7. MATERNITY LEAVE			5/3-7/03	MATERNITY LEAVE
8. EVERY WOMAN'S HEALTH	501 N. GRAHAM, #445 PORTLAND, OR 97227	BRENDA KEHOE, MD SENIOR PARTNER	7/03-5/04	PRIVATE PRACTICE
9. LOVE JOY SURGICENTRA	933 NW 25TH AVE PORTLAND, OR 97210	KAYLA REICH OWNER / ADMINISTRATOR	4/04- PRESENT	OUTPATIENT CLINIC
10. PROVIDENCE PORTLAND HOSPITAL	4805 NE ALISEN PORTLAND, OR 97213	DR. E CHARLES BOUVILLE MEDICAL STAFF PRESIDENT	4/03- 5/04	COURTESY HOSPITAL PRIVILEGES

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.

CK Burton

SIGNATURE

BURTON

PRINT LAST NAME

4/10/05

DATE

L6

RECEIVED
APR 2005
REGISTRATION SCHEDULING

STATE OF COLORADO DIVISION OF REGISTRATIONS

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

Department of Regulatory Agencies
Division of Registrations



CERTIFICATE OF MEDICAL EDUCATION

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

This certifies

that CAITLIN CADENA BURTON
FULL NAME OF APPLICANT

enrolled in

UNIVERSITY OF WASHINGTON, SCHOOL OF MEDICINE
FULL NAME OF MEDICAL SCHOOL

SEATTLE, WASHINGTON on the 20th day of SEPTEMBER
1993 error CS 4/10/05
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 20th day of Sept., 1993 and was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 13th day of June, 1997.

Signed and the college seal affixed

This 18th day of April, 2005

By Trudy L. Furberry Trudy L. Furberry, Certifying Officer

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:

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

STATE OF COLORADO

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

Department of Regulatory Agencies
Division of Registrations



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

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

APR 18 2005

****NO FEE REQUIRED****

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 CAITLIN CADENA BURTON
ADDRESS 10104 NW ENGLEMAN ST
CITY, STATE AND ZIP CODE PORTLAND, OR 97229
DATE OF BIRTH _____
SOCIAL SECURITY NUMBER _____
MEDICAL SCHOOL UNIV. OF WASHINGTON, SCHOOL OF MEDICINE
DATE OF GRADUATION 6/97

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

Caitlin Cadena Burton
Signature

4/10/05
Date

L7

Renewal - DR.0043725

Name	Caitlin G Clark
Credential	DR.0043725

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 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.

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
7155 E 38th Ave	Denver	Colorado	80207	(303) 321-7526

HPPP - MEDICAL Education and Training**Education and Training**

51. School or Education Level:

University of Washington School of Medicine

52. Please enter the year your initial Degree was achieved: *Only enter the year in YYYY format***HPPP GLOBAL - Other Licenses****Other Licenses**

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

Yes

HPPP GLOBAL - Other Licenses if Yes**Other Licenses**

54. Other Licenses:

State	License Status	Year Originally Issued
New York	Expired	1999
Oregon	Expired	2001
Nevada	Active	2015

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
Rose Medical Center	Affiliate	Denver

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?

No

HPPP GLOBAL - Business Ownership

Business Ownership

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

No

HPPP GLOBAL - Employer

Employer

65. Do you have an employer in the profession in which you are licensed or are applying for a license?
No

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?
Yes

HPPP GLOBAL - Employment Contracts if Yes

Employment Contracts

68. Employment Contracts:

Entity Name	Length of Contract	Contract Position
Caitlin Cadena Burton, MD PC	Unlimited	Employee

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:

04/28/2017

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.

Renewal - DR.0043725

Name	Caitlin Cadena Burton
Credential	DR.0043725

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:

- 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.0043725

Name	Caitlin Cadena Burton
Credential	DR.0043725

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

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:

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.

I. I have met the financial responsibility standards with an alternative method approved by the Colorado Division of Insurance. **Certification from the Division of Insurance is required.** Forward certification to the Colorado Medical Board, Attention: Renewal, 1560 Broadway Suite 1350, Denver, Colorado, 80202.

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.



Lookup Detail View

Licensee Information

This serves as primary source verification* of the license.

*Primary source verification: License information provided by the Colorado Division of Professions and Occupations, established by 24-34-102 C.R.S.

Name	Public Address
Caitlin G Clark	700 N Colorado Blvd Ste 179 Denver, CO 80206

Credential Information

License Number	License Method	License Type	License Status	Original Issue Date	Effective Date	Expiration Date
DR.0043725	Original	Physician	Active	06/28/2005	05/01/2017	04/30/2019

Board/Program Actions

Discipline
There is no Discipline or Board Actions on file for this credential.

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