

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
Susan Miller
Program Administrator

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

Department of Regulatory Agencies
Joseph A. Garcia
Executive Director

Division of Registrations
Bruce M. Douglas, Director



Roy Roemer
Governor

June 19, 1997

Valerie Anne Imperial, M.D.
625 Krameria
Denver, CO 80220

36089

Dear Dr. Imperial:

At a meeting of the Colorado Board of Medical Examiners held on June 19, 1997, your application for Colorado medical license was approved. Your license number is 36089, effective June 19, 1997.

Please keep us informed of any address changes as we will be sending, in the near future, a computer-generated pocket license followed by a wall license in a few months.

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, 1999 - 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

**Linda Joy,
Licensing Secretary**

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) 894-7888



APR 15 1997

STATE OF COLORADO

3054

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.

1a. Name:				1b. Social Security Number		OFFICE USE ONLY
Last	First	Middle	Degree			PERSONAL DATA
IMPERIAL	VALERIE	ANNE	MD			L7 <input checked="" type="checkbox"/>
2. Other names - <u>indicate if none.</u>						
NONE						
3. Mailing Address: <small>Number and Street/Rural Route, Apartment Number</small>						
248 WEST HAINES ST.						
<small>City</small>		<small>State</small>		<small>Zip</small>		<small>Country</small>
PHILADELPHIA		PA		19144		USA
4. Telephone Number: <small>(Area Code) Day Evening</small>			5. Date of Birth: <small>Mo/Dav/Year</small> Place of Birth:			
215-438-6516			MONTREAL, QUEBEC			
			<small>Submit a certified or notarized copy of your birth certificate or passport.</small>			
6. Sex		7. Have you ever filed an application in Colorado? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>		<small>If yes, give date of previous application</small>				
8. List name and address of college or university where pre-medical degree was received.						
<small>Request an official copy of transcript, with seal of school affixed, to be sent directly from school to this office. If transcript is not in English, send a certified English translation.</small>						
Name of School	Address and zip	Period of attendance				
		From (Mo/Yr)	To (Mo/Yr)			
University of Houston - University Park	4800 Calhoun Rd. Houston, TX 77204-2161	08/84	05/88	<input checked="" type="checkbox"/>		
9. List name and address of the school where professional medical degree was received.						
<small>Request an original L2 Form (Certificate of Medical Education) and an official copy of transcript with seal of school affixed. Certificate and transcript must be sent directly from the school to this office. If transcript is not in English, send a certified English translation.</small>						
Name of School	Address and zip	Period of attendance				
		From (Mo/Yr)	To (Mo/Yr)			
Baylor College of Medicine	One Baylor Plaza Houston, TX 77030	08/88	05/92	<input checked="" type="checkbox"/>		

Official use only

L1A 3/19/97

\$6155

Org. 8/86
Revised 9/92
Revised 11/95
Revised 4/96

L1A

10) Have you taken any of the following written examinations: National Boards, ECFMG, FLEX, LMCC, USMLE, or state written exam? Yes No

If yes, request certification of scores from each examination agency to be sent directly from examination agency to this office. (See "Summary of Requirements"). Provide photocopy of ECFMG Certificate if applicable. Provide information below:

Exam	Location	Date	Result
FLEX	AUSTIN, TEXAS	06/92	

WRITTEN EXAM

11. 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 L3 Form (Certificate of Completion of ACGME/AOA Postgraduate Training) from each facility attended for internship and residency training.

Name of facility	Address and zip	Specialty	Period of attendance:	
			From (Mo/Yr)	To (Mo/Yr)
Baylor College of Medicine	One Baylor Plaza Houston, TX 77030	Transitional Internship	08/92	06/93
Albert Einstein Medical Center	501 Old York Rd Philadelphia, PA 19141	OB-Gyn	07/93	06/97

POSTGRAD TRAINING

12. Are you now or have you ever been licensed to practice medicine in any state, territory, district, or country?

Yes No Include temporary licenses and instructional permits. Request verification from each to be sent to the Colorado Board of Medical Examiners. 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)
Pennsylvania	MT-031310-T	07/01/93	07/93	06/97
Pennsylvania	MD-057035-L	08/28/95	07/93	06/97
Texas	21010	06/92	06/92	06/93

LICENSE DATA

13. 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 L6 Form) Yes No

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 your license to practice 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

LICENSE DATA (continued)

REQ REC

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

REQ REC

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

REQ REC

GENERAL DATA

REQ REC

REQ REC

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?

Yes No

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

Date	Court address and zip	Violation	Penalty or disposition

REQ REC

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

REQ REC

24. You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado law, or claim one of the seven 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 an exemption applicable at the time you submit your application.

FIN



Valerie Anne Imperial

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 March 14 1997.

my age then being 31 years;

color of hair BLACK;

color of eyes BROWN;

height 5 ft. 1 in.;

weight 110 lbs.;

identifying marks Small mole
on left side of nasal
bridge.

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.

VALEDIE IMPERIAL 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 18-6-503, 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.

Valerie Anne Imperial

Signature

3-9-97

Date

STATE OF COLORADO

Department of Regulatory Agencies
Division Of Registration

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



BOARD OF MEDICAL EXAMINERS

APR 30 1997

STATE OF COLORADO

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that VALERIE ANNE IMPERIAL
FULL NAME OF APPLICANT
of 3607 ROBINSON RD, MISSOURI CITY, TEXAS
ADDRESS WHEN ENROLLED
enrolled in BAYLOR COLLEGE OF MEDICINE
FULL NAME OF MEDICAL SCHOOL
HOUSTON, TEXAS
LOCATION OF MEDICAL SCHOOL on the 28 day of July, 1988
1st day of August 1998

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

The undersigned certifies that the records of this institution show that he/she attended this institution beginning on 1st day of August, 1988 and was granted the degree Bachelor/Doctor of Medicine of Doctor of Osteopathy on 26th day of May, 1992.



Valerie Anne Imperial

Signed and the college seal affixed
this 21st day of April, 1997.
By Betty N. Williamson
Betty N. Williamson, Registrar, Secretary, Dean

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:

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

NOTE TO APPLICANT:

TRANSCRIPT OF MEDICAL SCHOOL CREDITS MAY BE SUPPLIED UNDER SEPARATE COVER.

Department of Regulatory Agencies
Division of Registrations

SEE INSTRUCTIONS ON REVERSE

BOARD OF MEDICAL EXAMINERS
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APR 15 1997



STATE OF COLORADO

REPORT OF PRACTICE HISTORY ORIGINAL LICENSURE

STATE OF COLORADO

Facility Name	Address and Zip	Reference (name & title)	Dates of Practice From - To	Nature of Practice
1. Baylor College of Medicine	One Baylor Plaza Houston, TX 77030.	Albert Watson, MD; Morse Levy, MD Co-directors, Transitional Program	6/24/92 to 6/23/93	Resident, Transitional Internship
2. Albert Einstein Medical Center	301 Old York Rd. Philadelphia, PA 19141	Sze-Ka Yeh, MD Chairman, Dept. of OB-Gyn	6/30/93 to 9/1/95 to	Resident, obstetrics and Gynecology
3. Chestnut Hill Hospital	2835 Germantown Avenue Philadelphia, PA 19118	Raul Neumann, MD Residency Director	6/30/97 to	House Physician
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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

I state under penalty of perjury in the second degree, as defined in 18-8-503, Colorado Revised Statutes, that the information contained in this application is true and correct to the best of my knowledge.

I understand that under the Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

SIGNATURE Valerie Anne Superior (Imperial) 4-5-97
DATE

SIGNATURE

Print Last Name

DATE

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Renewal - DR.0036089

Name	Valerie Anne Imperial
Credential	DR.0036089

Fee Details

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

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

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

Mail all documentation to:

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

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

1. Have you been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any health care facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law, whether involuntary or in lieu of investigation?

No

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

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

No

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

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

No

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

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

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.

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

KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

DR Renewal HPPP

Healthcare Professions Profiling Program ACTIVE status only:

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.

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.0036089

Name	Valerie Anne Imperial
Credential	DR.0036089

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:

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.0036089

Name	Valerie Anne Imperial
Credential	DR.0036089

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.

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
4500 E 9th Ave, #700	Denver	Colorado	80220	(303) 399-3315

HPPP - MEDICAL Education and Training

Education and Training

51. School or Education Level:

Baylor College of Medicine

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

1992

HPPP GLOBAL - Other Licenses

Other Licenses

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

No

HPPP GLOBAL - Board Certifications

Board Certifications

55. Do you hold any current Board Certifications?

Yes

HPPP - MEDICAL Board Certifications if Yes

Board Certifications

56. Board Certifications:

Certification
Obstetrics and Gynecology

HPPP GLOBAL - Practice Specialties

Practice Specialties

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

Yes

HPPP - MEDICAL Practice Specialties if Yes

Practice Specialties

58. Practice Specialties:

Specialty
Obstetrics and Gynecology

HPPP GLOBAL - CO Hospital Affiliations

Colorado Hospital Affiliations

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

Yes

HPPP GLOBAL - CO Hospital Affiliations if Yes

Colorado Hospital Affiliations

60. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
Rose Medical Center	Admitting Privileges	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?

Yes

HPPP GLOBAL - Employer if Yes

Employer

66. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
Partners in Women's Health	4500 E. 9th Ave, #700	Denver	Colorado	80220	(303) 399-3315

HPPP GLOBAL - Employment Contracts

Employment Contracts

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

No

HPPP GLOBAL - Disciplinary Actions

Disciplinary Actions

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

No

HPPP GLOBAL - Restrictions and Suspensions

Restrictions and Suspensions

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

No

HPPP GLOBAL - Healthcare Facility Actions

Healthcare Facility Actions

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

No

HPPP GLOBAL - Termination of Employment

Termination of Employment

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

No

HPPP GLOBAL - DEA Registration

DEA Registration Surrender

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

No

HPPP GLOBAL - Convictions

Convictions

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

No

HPPP GLOBAL - Malpractice Claims

Malpractice Claims

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

No

HPPP GLOBAL - Malpractice Carrier Refusal

Malpractice Carrier Refusal

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

No

HPPP GLOBAL - Optional Narrative

Optional Narrative

86. Optional Narrative:

HPPP GLOBAL - Attestation

Attestation

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

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

87. Submission Date:

04/04/2017

Review

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