DIV. OF REGISTRATIONS
APR23'12/00096

88 CK 1630 PAID
$569.00 CK
416333

Division of Registrations
Office of Licensing–Medical
(303) 894-7800 / FAX (303) 894-7693

Application for Original License
PHYSICIAN
Fee: $569

IMG

Not Board Certified

Name: Last: Kauvar	☒ MD ☐ DO	First: Lauren	Middle: Beth	Suffix:
Previous Name(s):				
Social Security Number: *		**Date of Birth** (mm/dd/yyyy):	**Gender:** ☐ Male ☒ Female	
Place of Birth (city and state, or foreign country): Denver, Colorado				
Mailing Address: *This is a* ☒ *Home* ☐ *Business*	PO Box, Street: 7321 Little Neck Pkwy Fl 2 City, State, Zip: Glen Oaks, NY 11004			
Daytime Telephone Number: (303) 918-6807	**E-mail Address:** *Preferred method for communication:* ☐ *Mail* ☒ *E-mail*			

PART 2—EDUCATION / TRAINING

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

Name of School	Location (address and ZIP)	Years Attended (from / to)	Year of Graduation
Tel Aviv University Sackler Faculty of Medicine NY State/American Program	17 E 62nd St NY, NY 10065	2003-2007	2007

► If this is an international medical school, please provide the country where the school is physically located: Israel

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

► **If YES,** provide information below:

Name of Facility	Specialty	Years Attended (from / to)
Long Island Jewish Medical Center	Ob/GYN	2008-2012

What is your specialty or specialties? Ob/GYN

***Social Security Number Disclosure:** Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in Title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's Social Security Number. Disclosure of your Social Security Number is mandatory for purposes of establishing, modifying, or enforcing child support under Sections 14-14-113 and 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by Section 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the National Practitioner Data Bank pursuant to 45 CFR Sections 60.1 et seq., and the Health Integrity and Protection Data Bank as required by 45 CFR Sections 61.1 *et seq.* Failure to provide your Social Security Number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your Social Security Number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your Social Security Number will not be released for any other purpose not provided for by law.

OFFICE USE ONLY **LICENSE NUMBER:** #51354 **DATE ISSUED:** 06/5/12

APPLICANT NAME: Lauren Beth Kauvar

PART 3—EXAMINATION / CERTIFICATION

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

Exam	Location	Date	Result
USMLE Step I	Colorado	7/12/2005	
USMLE Step II	Colorado	8/10/2006	
USMLE Step II CK	Illinois	8/18/2006	
USMLE Step III	New York	10/12/2009	

► If this is an international medical school, please provide the country where the school is physically located: Israel

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

► **If YES,** list certification information: _____

PART 4—LICENSE INFORMATION

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

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

Type of license	State/Country	License Number	Year license issued	Disciplinary action against license?	Is this license current/active?
Physician	New York	256432-1	2010	☐ YES ☒ NO	☒ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

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

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

Application type	License Number	Month and year license issued

PART 5—MALPRACTICE INSURANCE CERTIFICATION

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

Exemption Claimed: I currently reside outside of Colorado and claim exemption D set forth in the attached rule. I understand that before I engage in any medical practice in Colorado, I must obtain the required insurance or an acceptable equivalent.

APPLICANT NAME: Lauren Beth Kavvar

PART 6—SCREENING QUESTIONS

1. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic licensing board of any complaint, investigation, or inquiry which is currently pending? ☐ YES ☒ NO
   - ► **If YES,** give details below AND request official complaint and/or investigative report be sent directly to the Board from the licensing body, as well as personally submit a narrative regarding the complaint.

Agency	Date	Charge	Disposition

2. Has any healing arts license which you now hold or have ever held been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any healthcare facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question. ☐ YES ☒ NO
   - ► **If YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board, as well as a narrative regarding the action taken.

Agency	Date	Charge	Disposition

3. Have you ever entered into any agreement with any state, territory, district, country, U.S. government agency, and state medical/osteopathic board regarding your medical license? ☐ YES ☒ NO
   - ► **If YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason

4. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination in any state, country, or U.S. federal jurisdiction? ☐ YES ☒ NO
   - ► **If YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason for Denial

5. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in any other state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. ☐ YES ☒ NO
   - ► **If YES,** summarize below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason

APPLICANT NAME: _____

PART 6—SCREENING QUESTIONS (Continued)

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

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

Name of Facility	Date	Reason for Action

7. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law? Note: It is unnecessary to report traffic offenses that do not involve alcohol or drugs. ☐ YES ☒ NO

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

Date	Court	Violation	Penalty or Disposition

8. Do you now abuse or excessively use, or have you in the last five years abused or excessively used, any habit forming drug, including alcohol, or any controlled substance that has a) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or b) affected your ability to practice as a physician safely and competently?

9. In the last five years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a physician safely and competently, such as bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder?

You may answer NO to Question 8 or 9 if the behavior or condition is already known to the Colorado Physician Health Program (CPHP). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment, and/or monitoring.

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

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

APPLICANT NAME: _____

PART 6—SCREENING QUESTIONS (Continued)

10. Within the last five years, has any final judgment, settlement or arbitration award for medical malpractice been paid on your behalf or has any claim been filed which is still pending? ☐ YES ☒ NO

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

Date	Name and Address of Insurance Company	Reason for Action

11. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been canceled or rated at a higher premium due to past claims experience? ☐ YES ☒ NO

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

PART 7—SECURITY OF PATIENT MEDICAL RECORDS

☒ By checking this box, I attest that I have developed a written plan to ensure the security of patient medical records in compliance with C.R.S. 12-36-140.

ATTESTATION

I hereby make application for a license to practice medicine in the state of Colorado. In so doing, I authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associations (past and present), and all government agencies (local, state, federal and foreign), which includes state medical licensing boards and the Federation of State Medical Boards, to release to the licensing Board any information, files or records requested by the Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine during the processing of this application and the time that I am a licensee of this Board.

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

Lauren Beth Kawar
Signature of Applicant

4/18/12
Date

INTERNATIONAL MEDICAL GRADUATES QUESTIONNAIRE

This form is for international medical school graduates only. Please complete and return with your application.

SECTION 1 – SPECIALTY BOARD INFORMATION

Applicant Name: Lauren Beth Kawar

Medical School: Tel Aviv University Sackler Faculty of Medicine NY State / American Program

1. Do you currently hold specialty board certification issued through the American Board of Medical Specialties or the American Osteopathic Association? ☐ YES ☒ NO
   - ► If YES, please complete the following and request a letter of certification be sent directly from the specialty board to this office.

   Specialty Board: _____ Date of Certification: _____
2. If you are not Board certified, are you Board prepared? ☒ YES ☐ NO

SECTION 2 – MEDICAL SCHOOL QUESTIONS

INSTRUCTIONS:

Answer each of the questions below either YES or NO. In the case where you do not know the answer, check NO and provide an explanation on a separate sheet of paper. The mere statement that you do not know the answer is not adequate. You must make reasonable inquiry of your medical school for the information. If you have made reasonable inquiry and still have not been able to obtain the information requested, you must set out what reasonable effort you have conducted, including the names of all persons contacted in making your inquiry.

GOVERNANCE

1. At the time of your attendance, was your medical school a component of a university that had other graduate and other professional degree programs? ☒ YES ☐ NO
2. At the time of your attendance, was your medical school part of a not-for-profit university or chartered as a not-for-profit institution by the government of the jurisdiction in which it operated? ☒ YES ☐ NO

ADMINISTRATION

3. At the time of your attendance, did your medical school have a chief official or "Dean" qualified by education and experience to provide leadership in medical education? ☒ YES ☐ NO

EDUCATIONAL PROGRAM

4. At the time of your attendance, did your medical school provide at least 130 weeks of instruction? ☒ YES ☐ NO
5. At the time of your attendance, did the curriculum of your medical school include all of the following disciplines: anatomy, biochemistry, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine? ☒ YES ☐ NO
6. At the time of your attendance, did your medical school provide for laboratory or other practical exercises in the disciplines set out in question 5 above? ☒ YES ☐ NO
7. At the time of your attendance, did your medical school provide for clinical education programs involving actual patients in all of the following disciplines: family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery? ☒ YES ☐ NO
8. At the time of your attendance, were the clinical education programs mentioned in question 7 above conducted in teaching hospitals? ☒ YES ☐ NO
9. At the time of your attendance, did your medical school publicize to all faculty members and students its standards and procedures for the evaluation, advancement, and graduation of its students and for disciplinary action? ☒ YES ☐ NO

MEDICAL STUDENTS

10. At the time of your attendance, did your medical school require three or more years of undergraduate education for entrance into the medical school? ☒ YES ☐ NO
11. At the time of your attendance, were the criteria and procedures for the selection of students published and available to potential applicants and their undergraduate advisors? ☒ YES ☐ NO
12. At the time of your attendance, did your medical school provide financial aid to students? ☒ YES ☐ NO
13. At the time of your attendance, did your medical school provide a student health service available to all medical school students? ☒ YES ☐ NO

RESOURCES FOR THE EDUCATIONAL PROGRAM

14. At the time of your attendance, did your medical school only enroll the number of students that the school's total resources could accommodate? ☒ YES ☐ NO
15. At the time of your attendance, did your medical school have buildings and equipment that were quantitatively and qualitatively adequate to provide an environment conducive to high productivity of faculty and students? ☒ YES ☐ NO
16. At the time of your attendance, did the persons appointed to the faculty have demonstrated achievements within their disciplines commensurate with their faculty rank? ☒ YES ☐ NO
17. At the time of your attendance, did your medical school have a library, sufficient in size and breadth, to support the educational programs offered by the institution? ☒ YES ☐ NO
18. At the time of your attendance, did the library at your medical school have a library staff to supervise the library and to provide instruction in its use? ☒ YES ☐ NO

OTHER QUESTIONS AND REQUESTS FOR INFORMATION

1. What year was your medical school founded? 1976
2. **You must, in typewritten response, explain in your own words why you feel your medical school provided a high quality medical education. In your answer, please discuss the following: How did your medical school prepare its graduates to enter and complete graduate medical education to qualify for licensure, to provide competent medical care and to have the educational background for continued learning.**

I state under penalty of perjury in the second degree, as defined in 18-8-503, Colorado Revised Statutes, that the information contained herein 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.

Lauren Beth Kavan
Signature of Applicant

4/18/12
Date

To Colorado Division of Registrations- Office of Medical Licensing,

I am a graduate of Tel Aviv University Sackler Faculty of Medicine NY State/American Program. While this is considered a foreign medical school I believe that my medical education was totally comparable to the best medical schools within the USA. Israel is a country that is world renowned for its medical technology and advances, with much of that work originating at Tel Aviv University. All of our professors in both the classroom and in the hospitals conducted our learning in English and based off the same textbooks used in American medical schools. The quality of care for patients in Israel is equal to any hospital that I have worked at in the United States. My learning experiences in the hospital were extraordinary and more "hands on" than I have seen students experience in the USA. Aside from my time in Israel doing clinical rotations, I spent 4 months doing sub-internships in the USA during my 4th year of medical school. I felt that my knowledge and comfort in the hospital and with patient care was equivalent to my colleagues who attended medical school in the USA. After graduating from medical school, I was able to place into my top ranked Ob/Gyn Residency program in the USA- Long Island Jewish Medical Center. I am now completing the last months of residency training in Ob/Gyn. At no time in my training have I felt unprepared to practice medicine based on where I went to medical school. Tel Aviv University Sackler Faculty of Medicine NY State/American Program is an amazing educational and cultural experience that prepared me completely to be a competent practicing physician. That combined with my 4 years of residency training has given me the necessary skills to be an outstanding physician.

Sincerely,

Lauren B Kauvar MD

Lauren B Kauvar, MD

Colorado Division of Registrations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303) 894-7800 / FAX: (303) 894-7693
www.dora.state.co.us/registrations

REPORT OF PRACTICE HISTORY

(See instructions on following page)

	Dates of Practice From mm/yyyy	To mm/yyyy	Facility Name	Address (Street & Number, City, State, ZIP)	Reference (Name and Title)	Nature of Practice
1	08/07	02/08	Banner Good Samaritan Medical Center	1111 E. McDowell Rd Phoenix, AZ 85006	Alex McLaren, MD Residency Director	Orthopaedic Surgery Research
2	02/08	04/08	Vail Resorts	Vail, CO	Fred Rumford Ski School Supervisor	Ski Instructor
3	04/08	06/08	Cobrado Ski & Golf	2450 S. Havana st Aurora, CO 80014	Kevin Brannon Manager	Ski & Golf Sales
4	07/08	06/09	Long Island Jewish Medical Center	270-05 76th Ave New Hyde Park, NY 11040	Leah Kaufman, MD Residency director	Internship
5	07/09	06/12	Long Island Jewish Medical Center	270-05 76th Ave New Hyde Park, NY 11040	Leah Kaufman, MD Residency director	Residency
6						
7						
8						
9						
10						

Supplying false information in an application for a license is punishable by law.

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

Lauren Kavar MD — Kavar — 5/15/12

Applicant Signature | Applicant Last Name (print) | Date

2/2012

L6

Colorado Division of Registrations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303) 894-7800 / FAX: (303) 894-7693
www.dora.state.co.us/registrations

CERTIFICATE OF MEDICAL EDUCATION

SECTION 1

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

This certifies that Lauren Beth Kauvar
(Full Name of Applicant)

enrolled in Sackler Faculty of Medicine New York State/American Program
(Full Name of School)

Tel Aviv, Israel (Location of School) on the 31 (Day) day of August (Month), 2003 (Year).

SECTION 2

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

The undersigned certifies that the records of this institution show that s/he attended this Institution beginning on the 31 (Day) day of August (Month), 2003 (Year) and was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 21 (Day) day of May (Month), 2007 (Year).

Signed and the college seal affixed

This 23 (Day) day of May (Month), 2012 (Year).

By Leah Shulman (President / Secretary / Dean) Leah Shulman, Registrar

NOT VALID WITHOUT SCHOOL SEAL

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

L2

Colorado Division of Registrations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303) 894-7800 / FAX: (303) 894-7693
www.dora.state.co.us/registrations

REQUEST FOR FEDERATION OF STATE MEDICAL BOARDS (FSMB)—DISCIPLINARY ACTION REPORT

PHYSICIAN: To complete your application we must have a report from the Federation's National Databank of disciplinary actions taken by state licensing boards and/or other credentialing agencies. Note: an unfavorable report does not automatically disqualify you from licensure in Colorado.

Do not send this request form to the Colorado Office of Licensing.
When the FSMB receives the request form from you, they will provide the Disciplinary Action Report directly to the Colorado Board.

Complete this form and mail directly to:

Federation of State Medical Boards of the United States, Inc.
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3856

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

No fee is required.

Physician Name: Last: Kauvar	☒ MD ☐ DO	First: Lauren	Middle: Beth	Suffix:
Social Security Number:		**Date of Birth** (mm/dd/yyyy):		
Address: PO Box, Street: 7321 Little Neck Pkwy Fl 2 City, State, Zip: Glen Oaks, NY 11004				
Medical School: Tel Aviv University Sackler Faculty of Medicine NY State/American Program		**Date of Graduation:** 05/2007		

I hereby authorize and request that the Federation of State Medical Boards of the United States, Inc. provide a disciplinary history to the following:

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

Lauren Beth Kauvar
Signature

NO RETRIEVABLE INFORMATION
WE HAVE NO UNIVERSITY
REGARDING THE ABOVE NAMED PHYSICIAN

APR 17 2012

Humayun J. Chaudhry, D.O., FACP
President and CEO

4/5/2012
Date

Colorado Department of Regulatory Agencies
Division of Registrations
1560 Broadway, Suite 1350
Denver, CO 80202

Licensee/Applicant Full Legal Name

Last	First	Middle	Suffix
Kauvar	Lauren	Beth	

Colorado Professional or Occupational License/Certification/Registration Number: _____
(if already licensed)

Professional or Occupational License/Certification/Registration type applying for: Medical/Physician

AFFIDAVIT OF ELIGIBILITY

Pursuant to H.B. 06S-1009, 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.*

Section A: LAWFUL PRESENCE in the United States

1. ☒ I am a U.S. citizen. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
2. ☐ I am not a U.S. citizen, but I am lawfully present in the U.S. and authorized by the Department of Homeland Security to be employed in the U.S. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
3. ☐ I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.)
   a. ☐ I am a U.S. citizen, not physically present or employed in the United States.
   b. ☐ I am a Foreign National, not physically present or employed in the United States.

Section B: SECURE AND VERIFIABLE DOCUMENTS
Select ONE document in this section if you checked 1 or 2 in Section A.

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
☐ Driver's license or permit				
☐ Government issued ID card				
☐ Valid U.S. military ID/common access card				
☐ Colorado Department of Corrections inmate ID				
☐ Tribal ID card				
☒ U.S. passport	US Department of State	Lauren Beth Kauvar	220738194	12/20/2016
☐ Certificate of Naturalization				

Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
☐ Certificate of (U.S.) Citizenship				
☐ Valid Temporary Resident card				
☐ Valid I-94 issued by Canadian government				
☐ Valid I-94 with refugee/asylum stamp				

☐ Valid I-766 (Employment Authorization Card) — **Issuing federal agency:**

Name on card	Alien Number (A#)	Card Number	Valid from (mm/dd/yyyy)	Expires (mm/dd/yyyy)

☐ Valid I-551 (Resident Alien or Permanent Resident Card) — **Issuing federal agency:**

Name on card	Alien Number (A#)	Country of birth	Card expires (mm/dd/yyyy)	Resident since (mm/dd/yyyy)

☐ Valid foreign passport with an unexpired visa with proper classification for work authorization, and an unexpired I-94

Issuing foreign country	Passport Number	Visa Number	Visa Class (ex.: J-1, P-1, H-1B, etc.)	Date of entry (mm/dd/yyyy)	Until date (mm/dd/yyyy)

☐ Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa

Issuing foreign country:	Passport Number:

Section C: ATTESTATION

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.
- I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Lauren Beth Kauvar
Print Full Legal Name

Lauren Beth Kauvar
Signature (Full Name)

4/18/12
Date

Renewal - DR.0051354

Name	Lauren Beth Kauvar
Credential	DR.0051354

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:

7. Do you now abuse or excessively use, or have you in the last two years abused or excessively used, any habit forming drug, including alcohol, or any controlled substance that has a) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or b) affected your ability to practice as a physician safely and competently?

You may answer NO if the behavior or condition or use of such substances is already known to the Colorado Physician Health Program (CPHP) or you have entered into a Confidential Agreement with the Board. “Known to CPHP” means that you have informed CPHP of your behavior, condition or use of such substances and you are complying with all of CPHP’s requirements for evaluation, treatment and/or monitoring.

If you answer YES to question 7, you must provide a detailed summary of the behavior, condition or substance use. Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers.

8. In the last two years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a physician safely and competently, such as bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder?

You may answer NO if the behavior or condition or use of such substances is already known to the Colorado Physician Health Program (CPHP) or you have entered into a Confidential Agreement with the Board. “Known to CPHP” means that you have informed CPHP of your behavior, condition or use of such substances and you are complying with all of CPHP’s requirements for evaluation, treatment and/or monitoring.

If you answer YES to question 8, you must provide a detailed summary of the behavior, condition or substance use. Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers.

PART 2: MANDATORY ATTESTATION

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

I wish to to renew my license in ACTIVE status, therfore I attest that I meet (or claim exemption from) the financial responsibility standards as indicated below. (select the correct option A-I) If you are currently in Active status an wish to change to Inactive status you cannot renew online and must contact the Division at 303-894-2984.

I am currently in INACTIVE status and am exempt from the provisions above. (If so, you must select option "J"). *If you wish to change to ACTIVE status, you must first renew your license in inactive status, and then submit the reactivation application and fee. The reactivation application is available on the Medical Board website.

Please select only 1 item below.

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

DR Renewal HPPP

Healthcare Professions Profiling Program ACTIVE status only:

REMINDER:

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

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

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

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

Review

Please make sure to PRINT THIS SCREEN for your records. To do so, you can click the button in the upper right hand corner of this screen labeled "Print Review". You will not be able to print after you leave this review screen.

Renewal - DR.0051354

Name	Lauren Beth Kauvar
Credential	DR.0051354

Fee Details

Renewal Fee	$2.00
Renewal Fee	$238.00
Renewal Fee	$18.00
Renewal Fee	$162.00
	$420.00

Affidavit of Eligibility - Screening Present

AFFIDAVIT OF ELIGIBILITY

1. Do you currently reside in and are you physically present in the United States?
   Yes

Affidavit of Eligibility - Screening Doc Change

AFFIDAVIT OF ELIGIBILITY

2. Are you a United States Citizen and the State or Federally issued document, in which you proved your legal status in the United States is still valid **and** has not expired since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

-OR-

Are you Not a United States Citizen, but are lawfully present in the United States **and** your legal status within the United States has not changed **and** the legal documents used to prove lawful presence have not changed since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

If you need to update your lawful presence information, select no and you will be prompted to complete a new Affidavit of Eligibility. Otherwise, if your information has not changed, select yes to move forward.
   Yes

Affidavit of Eligibility

AFFIDAVIT OF ELIGIBILITY

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

** The word "licensure" is used as a general term. While most of the professions and occupations are licensed, others may be certified, registered or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.*

3. Please enter your Full Legal Name

Affidavit of Eligibility - Section A

Section A: LAWFUL PRESENCE in the United States

4. Select one of the following Lawful Presence types below and click "Next" when done:

Affidavit of Eligibility - Section B.1

Section B: SECURE AND VERIFIABLE DOCUMENTS

5. Do you have a State or Federal government issued identification?

These include:

- Driver's License or Permit
- Government Issued ID Card
- Valid U.S. Military Common Access Card
- Colorado Department of Corrections Inmate ID
- Tribal ID Card
- U.S. Passport
- Certificate of Naturalization
- Certificate of (U.S.) Citizenship
- Valid Temporary Resident card
- Valid I-94 issued by Canadian government
- Valid I-94 with refugee/asylum stamp

Affidavit of Eligibility - Section B.1 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

6. Select one of the following Government Issued Identification:

7. Enter the name of State or Federal Agency that issued the identification:

8. Enter your full name as shown on the driver's license or State/Federal issued identification:

9. Enter the State/Federal government issued license/ID number:

10. Enter the expiration date of the license/ID:

11. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.2

Section B: SECURE AND VERIFIABLE DOCUMENTS

12. Do you have a Valid I-766 (Employment Identification Card)?

Affidavit of Eligibility - Section B.2 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

13. Enter the issuing Federal Agency:

14. Enter the name as listed on the card:

15. Enter the Alien number (A#):

16. Enter the card number:

17. Enter the Valid From Date:

18. Enter the Expiration Date:

19. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.3

Section B: SECURE AND VERIFIABLE DOCUMENTS

20. Do you have a Valid I-551 (Resident Alien or Permanent Resident Card)?

Affidavit of Eligibility - Section B.3 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

21. Enter the issuing Federal Agency:

22. Enter the name as listed on the card:

23. Enter the Alien Number (A#):

24. Enter the country of birth:

25. Enter the card expiration date:

26. Enter the Residence Since date:

27. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.4

28. Do you have a Valid Foreign Passport with an unexpired Visa with proper classification for work authorization, and an unexpired I-94?

Affidavit of Eligibility - Section B.4 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

29. Enter the issuing foreign country:

30. Enter the Passport Number:

31. Enter the Visa Number:

32. Enter the Visa Class (Examples: J-1, P-1 H-1B, etc.):

33. Enter the Date of Entry:

34. Enter the Until Date:

35. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.5

Section B: SECURE AND VERIFIABLE DOCUMENTS

36. Do you have a valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa?

Affidavit of Eligibility - Section B.5 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

37. Enter the issuing foreign country:

38. Enter the Passport Number:

39. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section C

Section C: Attestation

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.
- I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in section 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified on the previous pages and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the information on the previous pages must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

40. By entering your full legal name below you attest that you have read and understand the above information.

41. Please enter today's date below:

DR Renewal Attestation

The below attestations apply to your license's CURRENT status. You may not change your status through online renewal. To change your status, please contact the licensing office at dora_registrations@state.co.us or 303-894-7800.

By renewing my license in INACTIVE status, I attest that:

- I understand malpractice insurance is not required for Inactive license holders; however, I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an Active license. I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee. I also understand that if I have not actively practiced medicine for two (2) years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.

By renewing my license in ACTIVE status, I attest that:

- I have not abused or excessively used any habit forming drug, including alcohol, or any controlled substance that has: 1) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or, 2) affected my ability to practice as a physician safely and competently, at any time during the past two years, up to and including today's date.

  AND

  In the last two years, I have not been diagnosed with or treated for an illness or condition that significantly disturbs my cognition, behavior, or motor function, and that may impair my ability to practice as a physician safely and competently, such as bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder

  OR

  The illness or condition or the use of substances, as defined above, is: 1) already known to the Colorado Physician Health Program ("CPHP") and I have made, or will make known within 30 days, any requisite disclosure to the Board pursuant to section 12-36-118.5 and any attendant regulations; or, 2) I have entered into a Confidential Agreement with the Board. For the purpose of this attestation, "Known to CPHP" means that I have informed CPHP of my condition or use of such substances and I am complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

- In the last 2 years, no adverse action has been taken against my license by another licensing agency, a peer review body, a health care institution, a residency or postgraduate training program, a professional or medical society or association, a governmental agency, a law enforcement agency, or a court for acts or conduct which, would constitute grounds for disciplinary or adverse actions pursuant to the Medical Practice Act or its attendant rules. For the purpose of this attestation, an adverse action by a law enforcement agency includes: 1) all felony charges; 2) all misdemeanor charges; or, 3) traffic charges/citations involving alcohol, controlled substances, or any other habit-forming drug.

  OR

  I have reported, or will report within 30 days, any adverse action to the Board in accordance with the requirements of the Medical Practice Act.

- In the last 2 years, I have not been denied medical liability insurance and no liability insurance coverage has been limited, restricted, or terminated by action of the insurance carrier in this or any other state.

  OR

  I have reported, or will report within 30 days, any denial or limitation of medical liability coverage to the Board.

- I have established and will continuously maintain professional liability insurance as required by §13-64-301, C.R.S.

Click Next to proceed.

GLOBAL HPPP Renewal Attestation

Pursuant to section 24-34-110, C.R.S., all Active and Retired status licensees must maintain a current Healthcare Professions Profile. Reportable events and/or changes to information must be made within 30 days. For more information about this Program and to update your profile, visit www.dora.colorado.gov/professions/hppp.

By renewing your Active or Retired license, you attest to the following:

I have updated my Healthcare Professions Profile to current date and/or I will make any updates within 30 days of any reportable event or change, and subsequent updates will be made within 30 days. This requirement is in addition to any requirement by a profession's practice act. Examples of reportable events or changes that must be updated on a profile include, but are not limited to, location of practice, public actions issued by any jurisdiction, felonies and crimes of moral turpitude, malpractice settlements/judgments, etc. To update a Healthcare Professions Profile, or for more information on the Healthcare Professions Profile Program (HPPP) and its requirements, visit www.dora.colorado.gov/professions/hppp or call 303-894-5942.

If your status is Inactive you are not required to maintain a Healthcare Professions Profile, click next to proceed.

You may NOT change your status through online renewal. For information regarding a status change, please contact the renewal desk at 303-894-7800 or dora_dpo_renewalline@state.co.us.

Click next to proceed.

Review

Please make sure to PRINT THIS SCREEN for your records. To do so, you can click the button in the upper right hand corner of this screen labeled "Print Review". You will not be able to print after you leave this review screen.

Renewal - DR.0051354

Name	Lauren Beth Kauvar
Credential	DR.0051354

Fee Details

DR - Legal Defense Fund	$2.00
DR - PDMP Fee	$24.00
DR - Portal Fee	$1.50
DR - Renewal Fee Active	$238.50
DR- Peer Fee	$162.00
	$428.00

Affidavit of Eligibility - Screening Present

AFFIDAVIT OF ELIGIBILITY

1. Do you currently reside in and are you physically present in the United States?
Yes

Affidavit of Eligibility - Screening Doc Change

AFFIDAVIT OF ELIGIBILITY

2. Are you a United States Citizen and the State or Federally issued document, in which you proved your legal status in the United States is still valid **and** has not expired since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

-OR-

Are you Not a United States Citizen, but are lawfully present in the United States **and** your legal status within the United States has not changed **and** the legal documents used to prove lawful presence have not changed since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

If you need to update your lawful presence information, select no and you will be prompted to complete a new Affidavit of Eligibility. Otherwise, if your information has not changed, select yes to move forward.
Yes

DR Renewal Attestation

The below attestations apply to your license's CURRENT status. You may not change your status through online renewal. To change your status, please contact the licensing office at dora_registrations@state.co.us or 303-894-7800.

By renewing my license in INACTIVE status, I attest that:

I understand malpractice insurance is not required for Inactive license holders; however, I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an Active license. I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee. I also understand that if I have not actively practiced medicine for two (2) years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.

By renewing my license in ACTIVE status, I attest that:

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

OR

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

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

- In the last 2 years, no adverse action has been taken against my license by another licensing agency, a peer review body, a health care institution, a residency or postgraduate training program, a professional or medical society or association, a governmental agency, a law enforcement agency, or a court for acts or conduct which, would constitute grounds for disciplinary or adverse actions pursuant to the Medical Practice Act or its attendant rules. For the purpose of this attestation, an adverse action by a law enforcement agency includes: 1) all felony charges; 2) all misdemeanor charges; or, 3) traffic charges/citations involving alcohol, controlled substances, or any other habit-forming drug.

OR

I have reported, or will report within 30 days, any adverse action to the Board in accordance with the requirements of the Medical Practice Act.

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

OR

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

1) The illness or condition is already known to the Colorado Physician Health Program (“CPHP”) and I have made, or will make known within 30 days, any requisite disclosure to the Board pursuant to section 12-36-118.5 and any attendant regulations; OR

2) I have entered into a Confidential Agreement with the Board. For the purpose of this attestation, “Known to CPHP” means that I have informed CPHP of my condition or use of such substances and I am complying with all of CPHP’s requirements for evaluation, treatment and/or monitoring; OR

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

- In the last 2 years, I have not been denied medical liability insurance and no liability insurance coverage has been limited, restricted, or terminated by action of the insurance carrier in this or any other state.

OR

I have reported, or will report within 30 days, any denial or limitation of medical liability coverage to the Board.

- I have established and will continuously maintain professional liability insurance as required by §13-64-301, C.R.S.

Click Next to proceed.

HPPP - DR Introduction

Healthcare Professions Profile

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

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

HPPP GLOBAL - Location of Practice

Location of Practice

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

Yes

HPPP GLOBAL - Location of Practice If Yes

Location of Practice

50. Practice Locations:

Address	City	State	Zip Code	Phone Number
425 S Cherry St Suite 300	Denver	Colorado	80246	(303) 388-4631

HPPP - MEDICAL Education and Training

Education and Training

51. School or Education Level:
Foreign Trained

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

2007

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	Inactive	2010

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
Medical Center of Aurora, The	Admitting Privileges	Aurora

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
Mile High Ob/Gyn P.C.	425 S Cherry St Suite 300	Denver	Colorado	80246	(303) 388-4631

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:
Associate professor at Rocky Vista University

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:
04/18/2017

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.

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
Lauren Beth Kauvar	Denver, CO 80246

Credential Information

License Number	License Method	License Type	License Status	Original Issue Date	Effective Date	Expiration Date
DR.0051354	International	Physician	Active	06/05/2012	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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