COLORADO STATE BOARD OF MEDICAL EXAMINERS

APPLICATION FOR A PHYSICIAN TRAINING LICENSE – FEE $10.00

Read all instructions prior to completing this application. All questions 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 if necessary.**

1 a. Name: Last	First	Middle	Degree	1b. Social Security Number
Linhorst	Jennifer	Ann	MD	

2. Other names (i.e. maiden name)- indicate if none.
None

3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE, Address provided is, by law, public information.)
☒ Home
☐ Business 2418 Road 11

City	State	Zip	Country
Waco	NE	68460	United States

E-mail address: jlinhorst@creighton.edu

4. Telephone Number: (Area Code) Day Evening	5. Date of Birth: Mo/Day/Year
(402) 650-8994	

6. Sex: Male (Female)

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

8. List name/address of the school where medical degree was received.

Name of School	City and State	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Creighton University	Omaha, NE	08/2003	05/2007

9. List the specialty program name address and phone number of the specialty training program into which you have been accepted.
Name Obstetrics and Gynecology University of Colorado Health Science Center
Address 4200 E. 9th Avenue, Box B-198 Denver, CO 80262 Phone # 303-315-3169

9a. What is your start date in this program?

9b. Is the training position you are filling a
☒ CATEGORICAL– a permanent position for the duration of your program?
☐ PRELIMINARY NON-DESIGNATED– you have not yet matched into a permanent program?
☐ PRELIMINARY DESIGNATED– from which you will transfer to _____ upon completion?
(name/location of subsequent program)

10. Have you received and/or completed additional postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs in addition to the program you have listed in question #9?
☐ Yes If yes, provide information below.
☒ No

Name of facility	Specialty	Period of attendance From (Mo/Yr)	Period of attendance To (Mo/Yr)

11. Are you now or have you ever been licensed to practice medicine in any state, territory, district or country? **Include temporary licenses and educational permits.**
☐ Yes If yes, provide information below.
☒ No

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

12. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic board of any complaint, investigation or inquiry, which is **currently pending?**
☐ Yes If yes, give details below. Request official complaint and/or investigative report be sent directly to the Board from the licensing body. Also submit your narrative regarding the complaint.
☒ No

State	Date	Charge	Disposition

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

State	Date	Charge	Disposition

2454

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

☐ **Yes** If yes, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

☒ **No**

Agency	Date	Reason

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

☐ **Yes** If yes, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

☒ **No**

Agency	Date	Reason for denial

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

☐ **Yes** If yes, summarize below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

☒ **No**

Agency	Date	Reason

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

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

☒ **No**

Name of facility	Date	Reason for action

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

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

☒ **No**

Date	Court	Violation	Penalty or disposition

19. Within the last five years, have you:

- Engaged in any behavior or suffered any mental, physical or cognitive health condition that has affected or might affect your ability to practice medicine safely and competently?
- Had any change in a condition described above that might affect your ability to practice medicine safely and competently?
- Illegally or excessively used any controlled substance, habit-forming drug, prescription medication or alcohol?
- Been diagnosed with or treated for bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder a neurological illness or sleep disorder that disturbs your cognition, behavior or motor function?

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

Yes If yes, submit explanation to the Board regarding the diagnosis or disorder(s). Be specific as to date of occurrences, the type of disorder involved, and what if anything has been done to treat the disorder. Please submit copies of any discharge summaries, evaluations, reports, DUI or DWAI records, police reports, and court records directly to the Board.

No

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

☐ **Yes** If yes, list below and complete the enclosed Claims Information Form.

☒ **No**

Date	Name and address of Insurance Company	Reason for Action

APPLICANT NAME: Jennifer Linhorst

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

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

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

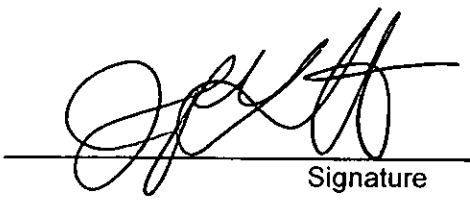
I state under penalty of perjury, as defined in 18-8-503, C.R.S., that the information contained in this application is true and correct to the best of my knowledge. I further state that I have read all disclosures contained in the application packet including the one related to social security numbers.

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

I understand that this license will apply only to the training program I am currently entering (listed below), and will only be transferable to a subsequent program if I am currently matched into that subsequent program as a requirement of my training program. I will not practice in any other subsequent training program until a new valid training license has been issued to me.

I understand that this license will only be valid for the training program listed below, and should I wish to practice medicine in Colorado outside the training environment, I would need to apply for a license to practice medicine in the State of Colorado.

I further understand that the issuance of this training license is not a guarantee of issuance of a license to practice medicine in the State of Colorado.



Signature

4/2/07
Date

RETURN THIS APPLICATION AND FEE TO:
COLORADO BOARD OF MEDICAL EXAMINERS
1560 BROADWAY, SUITE 1300
DENVER CO 80202-5140

T1C

This section to be completed by Program Director, Clinical Director or by Training Supervisor

(NOTE: If separate statement has already been submitted to the Board, this section does not need to be completed. Please check with your training program to see if this information has been submitted to the Medical Board.)

Name of Colorado Training Program/Specialty

University of Colorado Health Sci. Center – Obstetrics & Gynecology

Address of Training Program

4200 E. 9th Ave. Box B-198 Denver, CO 80262

I certify that this applicant meets the criteria set forth in 12-36-122 (2)(a) C.R.S., and that the training program indicated above, will accept responsibility for the applicant's medical training, while in the program.

This applicant is filling a

- [x] CATEGORICAL– a permanent position for the duration of their program.
- [ ] PRELIMINARY NON-DESIGNATED–they have not yet matched into a permanent program.
- [ ] PRELIMINARY DESIGNATED–from which they will transfer to the following upon completion:

(name/location of subsequent program)

As the Program Director, I understand that upon completion the program I have the responsibility to notify the Board that this applicant has completed their training in my program and will also advise the Board if the applicant is entering a subsequent training program after completion of the preliminary year(s). I further understand, and will advise the applicant, that if they are in a preliminary program attested to by my signature, that a signed attestation from the Program Director of the categorical (permanent) program must be submitted to the Board within 60-days of starting in that program, or their license will expire and they will need to reapply.

Ronald S Gibbs — 4/27/07

Signature of Program Director, Clinical Director or Supervising Physician of Colorado Training Program (Must be a Colorado Licensed Physician) — Date

Ronald S. Gibbs, M.D. — 29336

Print name — Colorado License number

Kendra Burghardt — 303-315-3169

Name of contact for program — Program contact phone number

RETURN THIS APPLICATION AND FEE TO:
COLORADO BOARD OF MEDICAL EXAMINERS
1560 BROADWAY, SUITE 1300
DENVER CO 80202-5140

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

AFFIDAVIT OF ELIGIBILITY

Pursuant to H.B. 06S-1009, C.R.S 24-34-107, **ALL** applicants for original licensure or licensees renewing a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) Jennifer Ann Linhorst, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check 1, 2 or 3 below):

1. X I am a US citizen.

2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
   a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641.
   b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended.
   c. ___ I am an alien who is paroled into the US under 8 U.S.C. sec. 1182 (d) (5).

3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
   a. ___ I am a US 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.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided upon request only.

   - ☐ Any Colorado Driver License, Colorado Driver Permit or Colorado Identification Card, expired less than one year. (Temporary paper license with invalid Colorado Driver License, Colorado Driver Permit, or Colorado Identification Card, expired less than one year is considered acceptable.)
   - ☒ Out-of-state issued photo Driver's License or photo identification card, photo driver's permit expired less than one year.
   - ☐ Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa.
   - ☐ Valid I-551 Resident Alien or Permanent Resident card.
   - ☐ Valid foreign passport accompanied by an "I-94" indicating a specific future "until" date.
   - ☐ Valid I-94 issued by Canadian government with L1 or R1 status and a valid Canadian driver's license or valid Canadian identification card.
   - ☐ Valid Temporary Resident Card.
   - ☐ Valid I-94 with refugee/asylum stamp.

(document list continued on page 2)

PAID
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- ☐ Valid 1688B or 1766 Employment Authorization Card.
- ☐ Valid US Military ID (active duty, dependent, retired, reserve and National Guard).
- ☐ Tribal Identification Card with intact photo (US or Canadian).
- ☐ Certificate of Naturalization with intact photo.
- ☐ Certificate of (US) Citizenship with intact photo.
- ☐ Passport issued by the U.S. Government with one of the following documents: Social Security card; marriage, divorce or separation certificate or decree; or a Colorado or Federal tax return.
- ☐ Colorado Department of Corrections Inmate Identification Card with a Social Security card issued by the United States Government.

2. Enter the state or the federal agency name where this secure and verifiable document was issued.
Nebraska
(If issued by a state agency, include both the state and agency name.)

3. What is the secure and verifiable document number? H1235 2670

4. What is the expiration date of your secure and verifiable document? 10 / 03 / 2011 (month/day/year)
(If you hold a document without an expiration date, such as a military ID or naturalization certificate, write N/A.)

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.

Signature

4-2-07
Date

Jennifer A. Linhorst
Please print your name as shown on your secure and verifiable document.

Professional License Type: Physician Training License

License Number (if already licensed): _____

DIV. OF REGISTRATIONS 937
FEB 1'11/ 00059

Division of Registrations
Office of Licensing–Medical
(303) 894-7800 / FAX (303) 894-7693
www.dora.state.co.us/registrations

522.00 CB
354952

Application for Original License
PHYSICIAN
Fee: $522

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

PART 1—APPLICANT INFORMATION

Name: Last: Linhorst	☒ MD ☐ DO	First: Jennifer	Middle: Ann	Suffix:
Previous Name(s): N/A				
Social Security Number: *	**Date of Birth** (mm/dd/yyyy):	**Gender:** ☐ Male ☒ Female		
Place of Birth (city and state, or foreign country): Seward, Nebraska				
Mailing Address: *This is a* ☒ *Home* ☐ *Business*	PO Box, Street: 1550 Detroit Street #201 City, State, Zip: Denver, CO 80204			
Daytime Telephone Number: (303) 968-5775	**E-mail Address:** jlinhorst@hotmail.com *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
Creighton University	2500 California Plaza Office of Medical Education Criss III Room 463, Omaha, NE 68178	2003-2007	2007

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

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)
University of Colorado	OB-Gyn	2007-2011

What is your specialty or specialties? Obstetrics & Gynecology

*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 disciplinary actions 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: 49707 DATE ISSUED: 2/16/11 DB

TL 2454

CK#1068 2/7/11

APPLICANT NAME: Jennifer Ann Linhart

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 1	Omaha, Nebraska	10/7/2005	
USMLE Step 2	Omaha, Nebraska	10/18/2006	
USMLE Step 3	Longmont, Colorado	2/26/2008	

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

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?
Training Licence	Colorado, USA	TL 2454	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: N/A, See attached Document

APPLICANT NAME: Jennifer Ann Linhoff

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: Jennifer Ann Linhorst

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: You must respond YES even if the charge(s) or action was ultimately dismissed, pardoned, or the matter was not prosecuted. 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: Jennifer Linhorst

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.

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.

Signature of Applicant

Date 1/14/11

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
07/2007	06/2008	University of Colorado	12631 E. 17th Avenue Aurora, CO 80045	Dr. Ruben Alvero Director Obstetrics & Gynecology Residency Program	Intern
7/2008	6/2011	University of Colorado	12631 E 17th Avenue Aurora, CO 80045	Dr. Ruben Alvero Director Obstetrics & Gynecology Residency Program	Residency

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.

Applicant Signature — Linhorst (Applicant Last Name (print)) — 1/14/11 (Date)

9/2010

L6

DIV. OF REGISTRATIONS 984

FEB14'11/ 00867

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 Jennifer Ann Linhorst
Full Name of Applicant

enrolled in Creighton University School of Medicine
Full Name of School

Omaha, Nebraska on the ____ day of ____, ____.
Location of School Day Month 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 18th Day of August, 2003 and was granted the degree

~~Bachelor~~/Doctor of Medicine ~~or Doctor of Osteopathy~~ on the 12th Day of May, 2007.

Signed and the college seal affixed

This 28th Day of January, 2011.

By _____
President / Secretary / Dean
Michael G. Kavan, Ph.D.
Associate Dean for Student Affairs

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
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Denver, CO 80202
Phone: (303) 894-7800
www.dora.state.co.us/registrations

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

SECTION 1

To be completed by applicant and forwarded to the facility where postgraduate training was received and/or completed.

This certifies that Jennifer Ann Linhorst
Full Name of Applicant

a graduate of ~~Univ~~ Creighton University School of Medicine
Full Name of Medical/Osteopathic School

commenced postgraduate training at University of Colorado, Aurora Colorado
Name and Address of Facility

SECTION 2

To be completed by the program director of the facility for ACGME/AOA postgraduate training in the United States or Canada.

on 25 JUNE, 2007 and satisfactorily completed or will complete such training on 30 JUNE, 2011.

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

List type and length of training.

ROTATION	LENGTH OF ROTATION
OBSTETRICS AND GYNECOLOGY	48 months

Was this physician's performance completely satisfactory?

▶ **If NO, please attach an explanation.**

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

Program Director RUBEN ALVERO, MD

Address 12631 E. 17th Ave. B198-6, Aurora, CO 80045

Phone Number 303-724-2052 Date 1/28/11

Signature

L3

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
PO Box 619850
Dallas, TX 75261-9850

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

No fee is required.

Physician Name: Last: Linhoff	☒ MD ☐ DO	First: Jennifer	Middle: Ann	Suffix:
Social Security Number:		**Date of Birth** (mm/dd/yyyy):		
Address: PO Box, Street: 1550 Detroit Street Apt 201				
City, State, Zip: Denver, CO 80206				
Medical School: Creighton University SOM		**Date of Graduation:** 5/12/2007		

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

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

FEB 0 8 2011

Signature

1/14/11
Date

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

University of Colorado at Denver

School of Medicine
Office of Graduate Medical Education

13001 E. 17th Pl, C293, Aurora, CO 80045
Phone: 303-724-6031; Fax: 303-724-6034

CONFIRMATION OF MALPRACTICE COVERAGE

Date: January 4, 2011

*Resident: Jennifer Linhorst, M.D.
Program start date: 6/23/2007
Program end date: Until completion of program

The University of Colorado Denver provides medical malpractice coverage for its employees, residents, students, and volunteers through a combination of self-insurance and commercial insurance. This coverage is subject to the terms of the University of Colorado Self-Insurance and Risk Management Trust Coverage Document. Coverage extends to injuries arising from acts or omissions occurring during the performance of the covered person's duties and within the scope of the covered person's duties and within the scope of the covered person's employment or training, unless the act or omission was willful and wanton.

The Trust's coverage extends to employees, residents, students, and volunteers defined in the Trust Coverage Document and in accordance with the Colorado Governmental Immunity Act (C. R. S. 24-10-101 et. seq.). These employees, residents, students, and volunteers are considered to be "public employees" under the Colorado Governmental Immunity Act and their liability is limited by the Act as follows:

(a) for any injury to one person in any single occurrence, the sum of $150,000;
(b) for any injury to two or more persons in any single occurrence, the sum of $600,000; except in such instance, no person may recover in excess of $150,000.

For claims subject to the protection of the Colorado Governmental Immunity Act, if a court of competent jurisdiction rules as final judgment that the limitations of the Act are not applicable to the University, the University of Colorado Hospital, a particular public employee, faculty member, or student, then the Trust provides secondary coverage through a commercial policy which has limits of at least $6,000,000 per occurrence and $6,000,000 in aggregate. Both the coverage under the Colorado Governmental Immunity Act as well as the secondary coverage provided be the Trust which are outlined above apply to acts that occurred within the course and scope of the employees work for the university or which occurred during the time that the resident or student was enrolled in the program.

All inquiries regarding the coverage provided or claims history for the individual named above should be directed to the Office of Professional Risk Management, Mail Stop F407, 13001 E. 17th Place, Aurora, CO 80045.

Carol M. Rumack, M.D./Designee
Associate Dean
Graduate Medical Education

* ACGME defines "resident" as intern, resident, and fellow.

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

AFFIDAVIT OF ELIGIBILITY

Pursuant to H.B. 06S-1009, C.R.S 24-34-107, **ALL** applicants for original licensure or licensees renewing a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) Jennifer Ann Linhorst, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check 1, 2 or 3 below):

1. X I am a US citizen.

2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
   - a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641.
   - b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended.
   - c. ___ I am an alien who is paroled into the US under 8 U.S.C. sec. 1182 (d) (5).

3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
   - a. ___ I am a US 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.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided upon request only.

- ☒ Any Colorado Driver License, Colorado Driver Permit or Colorado Identification Card, expired less than one year. (Temporary paper license with invalid Colorado Driver License, Colorado Driver Permit, or Colorado Identification Card, expired less than one year is considered acceptable.)
- ☐ Out-of-state issued photo Driver's License or photo identification card, photo driver's permit expired less than one year.
- ☐ Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa.
- ☐ Valid I-551 Resident Alien or Permanent Resident card.
- ☐ Valid foreign passport accompanied by an "I-94" indicating a specific future "until" date.
- ☐ Valid I-94 issued by Canadian government with L1 or R1 status and a valid Canadian driver's license or valid Canadian identification card.
- ☐ Valid Temporary Resident Card.
- ☐ Valid I-94 with refugee/asylum stamp.

(document list continued on page 2)

- ☐ Valid 1688B or 1766 Employment Authorization Card.
- ☐ Valid US Military ID (active duty, dependent, retired, reserve and National Guard).
- ☐ Tribal Identification Card with intact photo (US or Canadian).
- ☐ Certificate of Naturalization with intact photo.
- ☐ Certificate of (US) Citizenship with intact photo.
- ☐ Passport issued by the U.S. Government with one of the following documents: Social Security card; marriage, divorce or separation certificate or decree; or a Colorado or Federal tax return.
- ☐ Colorado Department of Corrections Inmate Identification Card with a Social Security card issued by the United States Government.

2. Enter the state or the federal agency name where this secure and verifiable document was issued.
Colorado
(If issued by a state agency, include both the state and agency name.)

3. What is the secure and verifiable document number? 07-248-1253

4. What is the expiration date of your secure and verifiable document? 10 / 03 / 2012 (month/day/year)
(If you hold a document without an expiration date, such as a military ID or naturalization certificate, write N/A.)

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.

Signature _____ Date 1/14/11

Jennifer Ann Linhorst
Please print your name as shown on your secure and verifiable document.

Professional License Type: Training license

License Number (if already licensed): TL2454

Renewal - DR.0049707

Name	Jennifer Ann Linhorst
Credential	DR.0049707

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.

D. I maintain commercial professional liability insurance with a company other than those listed in A, B, or C above that is authorized to do business in Colorado, in minimum indemnity amounts of at least $1,000,000 per incident and $3,000,000 annual aggregate per year. Please submit an e-mail with the name of that company to **DORA_MedicalBoard@state.co.us**.

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.0049707

Name	Jennifer Ann Linhorst
Credential	DR.0049707

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.0049707

Name	Jennifer Ann Linhorst
Credential	DR.0049707

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 South Cherry Street Suite 300	Denver	Colorado	80246	(303) 388-4631
501 East Hamden Ave	Englewood	Colorado	80113	(303) 788-5000
3480 Centennial Blvd	Colorado Springs	Colorado	80206	(719) 475-7162
7155 East 38th Ave	Denver	Colorado	80206	(303) 321-2458

HPPP - MEDICAL Education and Training

Education and Training

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

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
South Dakota	Expired	2013

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	Faculty	Denver
Swedish Medical Center	Admitting Privileges	Englewood

HPPP GLOBAL - Other Hospital Affiliations

Other Health Care Facilities and Out of State Hospital Affiliations

61. Do you have a current affiliation with any healthcare facility or a non-Colorado hospital?
Yes

HPPP GLOBAL - Other Hospital Affiliations If Yes

Other Health Care Facilities and Out of State Hospital Affiliations

62. Other Healthcare Facility Affiliations:

Facility	Affiliation Type	City	State
Planned Parenthood	Other	Colorado Springs	Colorado

Planned Parenthood	Other	Stapleton	Colorado

HPPP GLOBAL - Business Ownership

Business Ownership

63. Do you have a current business ownership interest in any healthcare-related business?
No

HPPP GLOBAL - Employer

Employer

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

HPPP GLOBAL - Employment Contracts

Employment Contracts

67. Do you have a contract with any business whose mission relates to healthcare services or products where the value is greater than $5000 annually?
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:
04/06/2017

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
Jennifer Ann Linhorst	Denver, CO 80206

Credential Information

License Number	License Method	License Type	License Status	Original Issue Date	Effective Date	Expiration Date
DR.0049707	Original	Physician	Active	02/16/2011	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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Lookup Detail View

Licensee Information

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*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
Jennifer Ann Linhorst	Denver, CO 80206

Credential Information

License Number	License Method	License T ype	License Status	Original Issue Date	Effective Date	Expiration Date
TL.0002454	Original	Physician Training License	Expired	06/23/2007	09/01/2010	02/16/2011

Board/Program Actions

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

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