STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
Susan Miller
Program Administrator

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

Department of Regulatory Agencies
Joseph A. Garcia
Executive Director

Division of Registrations
Bruce M. Douglas, Director

Roy Romer
Governor

February 17, 1998

Pamela A. Bock, M.D.
5764 Bloomfield Glens
West Bloomfield, MI 48322

36747

Dear Dr. Bock:

At a meeting of the Colorado Board of Medical Examiners held on February 12, 1998, your application for Colorado medical license was approved. Your license number is 36747 effective February 12, 1998.

Please keep us informed of any address changes as we will be sending, in the near future, a computer-generated pocket license followed by a wall license in a few months. (Please note that your preferred mailing address is available to the public.)

All physician licenses expire during May of each odd numbered year, and once renewed are good for a two year period. Your license will expire May 31, 1999 - please note this date. Notice of the renewal fee will be sent to you at the last address of record in our files. It is important to inform the Board of any changes in work or home address in order to ensure that your renewal packet will reach you in a timely manner. A second renewal notice is not required by law. It is the responsibility of each physician to remit the registration fee to this office, even though the original notice fails to reach the physician. The Board cannot assume responsibility for changes of address that do not reach its office.

Sincerely,

FOR THE BOARD OF MEDICAL EXAMINERS

Linda Joy,
Licensing Secretary

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

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

BOARD OF MEDICAL EXAMINERS
NOV 13 1997
STATE OF COLORADO

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE

READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS APPLICATION. ALL QUESTIONS ON THIS APPLICATION MUST BE ANSWERED, AI SUPPORTING DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION PER INSTRUCTIONS. THE ENCLOSED CHECKLIST IS PROVIDE YOUR CONVENIENCE. PLEASE TYPE OR PRINT NEATLY. WHEN SPACE PROVIDED IS INSUFFICIENT, ATTACH ADDITIONAL SHEETS OF F YOU MAY REPRODUCE THESE BLANK FORMS AS NEEDED, BUT EACH COMPLETED FORM YOU SUBMIT MUST BE IN ORIGINAL INK OR **MAKE SUFFICIENT COPIES OF ALL FORMS BEFORE YOU BEGIN.**

OFFICE USE

1a. Name: Last: BOCK, First: PAMELA, Middle: ANNE, Degree: M.D.

1b. Social Security Number: Redacted

PERSONAL DATA

2. Other names - indicate if none.
~~NONE~~ PAG 3/14/97 MORÓN, PAMELA ANNE

L7 ☒

3. Mailing Address: Number and Street/Rural Route, Apartment Number
5764 BLOOMFIELD GLENS

City: WEST BLOOMFIELD, State: MICHIGAN, Zip: 48322, Country: U.S.A.

4. Telephone Number: (Area Code) Day: 248-684-1800 Evening: 248-626-6603

5. Date of Birth: Mo/Day/Year: Redacted
Place of Birth: EL PASO, TEXAS
Submit a certified or notarized copy of your birth certificate or passport.

BC ☒

6. Sex: Male (Female)

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

PRE-MED

8. List name and address of college or university where pre-medical degree was received.

Request an official copy of transcript, with seal of school affixed, to be sent directly from school to this office. If transcript is not in English, send a certified English translation.

Name of School	Address and zip	Period of attendance	
		From (Mo/Yr)	To (Mo/Yr)
Wayne State University	OFFICE OF THE REGISTRAR DETROIT, MI 48202	9/1978	4-1983

☒

MEDICAL / CME ☒

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

Name of School	Address and zip	Period of attendance	
		From (Mo/Yr)	To (Mo/Yr)
Wayne State University School of Medicine	504 E. CANFIELD DETROIT, MI 48201	8/1983	6-1987

☒

Official use only

License # 36747 Date 2/12/98

Fee$ 320— Date 11/13/97

8985

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

L1A

OFFICE USE ONLY

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

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

Exam	Location	Date	Result
National Boards Part I, II, III	Detroit, Michigan	1985, 1987, 1988	Redacted

WRITTEN EXAM ☒ ☐ ☐ ☐

11. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian facilities?
☒ Yes ☐ No
If yes, provide information below. Request an original L3 Form (Certificate of Completion of ACGME/AOA Postgraduate Training) from each facility attended for internship and residency training.

Name of facility	Address and zip	Specialty	Period of attendance: From (Mo/Yr)	To (Mo/Yr)
Wayne State University/ Detroit Medical Center	4201 St. Antoine Detroit, MI 48201	Obstetrics And Gynecology	July 1987	June 1991

POSTGRAD TRAINING ☒ ☐ ☐

12. Are you now or have you ever been licensed to practice medicine in any state, territory, district, or country?
☒ Yes ☐ No Include temporary licenses and instructional permits. Request verification from each to be sent to the Colorado Board. See Instructions. **If yes, provide information below:**

State or country	License number	Date of issue	Dates of practice in this jurisdiction: From (Mo/Yr)	To (Mo/Yr)
Michigan	No. 52014	October 13, 1988	Aug 1991	Currently

LICENSE DATA ☒ ☐ ☐ ☐ ☐

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

L6 ☒

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

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

If yes, give details below:

State	Date	Charge	Disposition

REQ REC ☐ ☐ ☐ ☐ ☐ ☐

16. Has **any disciplinary action** ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. military, U.S. Public Health Service, or other U.S. federal governmental entity. (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations currently pending.) ☐ Yes ☒ No

If yes, give details below.

State or government agency	Date	Charge	Disposition

REQ REC ☐ ☐ ☐ ☐

OFFICE USE
LICEN DAT (contin

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

☐ Yes ☒ No

If yes, give details below:

State or government agency	Date	Reason for denial

REQ ☐ ☐

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

☐ Yes ☒ No

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

State	Date	Reason for surrender

REQ ☐ ☐

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

☐ Yes ☒ No

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

Name of facility	Address and zip	Date	Reason for Action

REQ ☐ ☐

GENER DAT

20. Within the last five years, have you engaged in any behavior or experienced any mental or physical health condition that might impair your ability to practice medicine safely and competently?

Redacted

If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of behavior or condition involved, and what if anything has been done to correct the behavior or condition.

REQ ☐

21. Within the last five years, have you illegally or excessively used any controlled substance, habit forming drug, prescription medication, or alcohol?

Redacted

If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of behavior involved, and what if anything has been done to correct the behavior.

REQ ☐

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

☐ Yes ☒ No

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

Date	Court address and zip	Violation	Penalty or disposition

REQ ☐ ☐

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

☐ Yes ☒ No

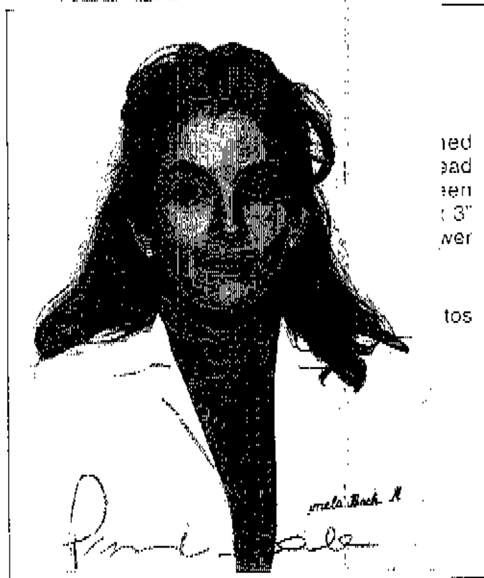
If yes, give details below: Include any conviction that has been set aside, dismissed, or pardoned under the Constitution of Colorado, article IV, section 7, or under any other provision of law.

Date	Court address and zip	Violation	Penalty or disposition

REQ ☐ ☐

24. You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado law, or claim one of the seven exemptions set forth in the enclosed Insurance memo. See instructions in application packet, and include proof of insurance (obtained from your insurance carrier) or include a statement setting forth the basis for an exemption applicable at the time you submit your application.

INS



I hereby declare under penalty of perjury under the laws of the State of Colorado, that the photo of myself attached hereto, was taken

on or about 11 / 4, 1997

my age then being 37 years;

color of hair AUBURN;

color of eyes BROWN;

height 5 ft. 3 in. ;

weight 130 lbs.;

identifying marks

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, PAMELA A. BOCK. hereby make application for a license to practice medicine in the State of Colorado.

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

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

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

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

[signature]
Signature

March 14, 1997
Date

L1D

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS

Department of Regulatory Agencies
Division Of Registration

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

NOV 17 1997
STATE OF COLORADO

RECEIVED NOV 7 1997 RECORDS & REGISTRATION OFFICE WSU SCHOOL OF MEDICINE

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Pamela Anne Moran (Bock)
FULL NAME OF APPLICANT

of Detroit, MI
ADDRESS WHEN ENROLLED

enrolled in Wayne State University - School of Medicine
FULL NAME OF MEDICAL SCHOOL

Detroit, Michigan on the 2 day of ~~June~~ August, 19~~87~~ 83
LOCATION OF MEDICAL SCHOOL

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

The undersigned certifies that the records of this institution show that he/she attended this institution beginning on 29th day of August, 19 83 and was granted the degree Bachelor/Doctor of Medicine or Doctor Osteopathy on 2nd day of June, 1987.

Signed and the college seal affixed

this 7th day of November, 1997

By Sandra J. Russell
President, Secretary, Dean

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:

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

NOTE TO APPLICANT:

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

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS

Department of Regulatory Agencies
Division of Registrations

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

DEC - 3 1997
STATE OF COLORADO

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

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

This is to certify that Pamela Anne Murón (Bock), MD
NAME OF APPLICANT

a graduate of Wayne State University - School of Medicine
NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in WAYNE STATE UNIVERSITY / DETROIT MEDICAL CENTER
NAME AND ADDRESS OF FACILITY
4201 ST. ANTOINE
DETROIT, MI 48201

on July 1, 1987, and satisfactorily completed such training

on June 30, 1991. This training consisted of 48 months of actual clinical instruction and is approved by the Accredited Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

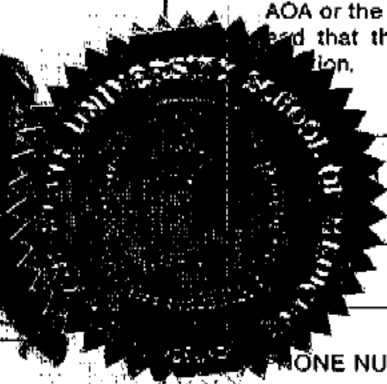
List type and length of training.

ROTATION	LENGTH OF ROTATION
Obstetrics And Gynecology	4 YEARS

WAS THIS PHYSICIAN'S PERFORMANCE COMPLETELY SATISFACTORY? PLEASE CHECK ONE

Redacted

IF NO, PLEASE ATTACH AN EXPLANATION.



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

Mary F. Euth
PROGRAM DIRECTOR

NOT VALID WITHOUT SEAL

4201 St. Antoine
Detroit, Michigan 48201

PHONE NUMBER (313) 745-5146

DATE November 7, 1997

SIGNATURE Mary F. Euth

L3

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS

Department of Regulatory Agencies
Division of Registrations

SEE INSTRUCTIONS ON REVERSE

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

NOV 13 1997

STATE OF COLORADO

REPORT OF PRACTICE HISTORY
ORIGINAL LICENSURE

	Facility Name	Address and Zip	Reference (name & title)	Dates of Practice From – To	Nature of Practice
1.	WAYNE STATE UNIVERSITY / DETROIT MEDICAL CENTER	4201 ST. ANTOINE DETROIT, MI 48201	MITCHELL DOMBROWSKI, MD CHAIR, DEPT. OF OB/GYN	JULY 1987 – 6/91	RESIDENT OB/GYN
2.	HURON VALLEY-SINAI HOSPITAL	1601 E. COMMERCE RD COMMERCE TWNSHIP, MI 48382-1271	M. O. BAYRAM, MD CHIEF, DEPT. OF OB/GYN	JULY 1991 – PRESENT	ACTIVE STAFF OB/GYN
3.	GRACE HOSPITAL	6071 W. OUTER DRIVE DETROIT, MI 48235	BERNARD GONIK, MD CHIEF, DEPT. OF OB/GYN	JULY 1991 – PRESENT	ACTIVE STAFF OB/GYN
4.	HUTZEL HOSPITAL	4707 ST. ANTOINE DETROIT, MI 48201	MITCHELL DOMBROWSKI, MD CHIEF, DEPT. OF OB/GYN	JULY 1991 – PRESENT	ACTIVE STAFF OB/GYN
5.	SINAI HOSPITAL	6767 W. OUTER DRIVE DETROIT, MI 48235	DAVID SCHWARTZ, MD CHIEF, DEPT. OF OB/GYN	1992 – 1994	ACTIVE STAFF OB/GYN
6.					
7.					
8.					
9.					
10.					

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

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

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

[signature] M.D. (BOCK) 11/2/97

SIGNATURE — Print Last Name — DATE

L6

COLORADO BOARD OF MEDICAL EXAMINERS 1999 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	M	SOCIAL SECURITY #	COLORADO 5 DIGIT LICENSE #
BOCK	PAMELA	A	Redacted	36747

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

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

1 2 3 4 5 6 7 8 9 0

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

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

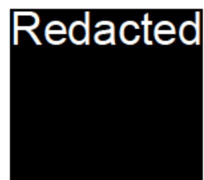
	YES	NO
1 had any adverse action taken against you by any licensing agency in another state or country, any peer review body, any health care institution, any professional or medical society or association, any governmental agency, any law enforcement agency, or any court?	☐	☑
2 surrendered a license or other authorization to practice medicine in another state or jurisdiction or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?	☐	☑
3 had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? (Note Please include any payments you have personally made)	☐	☑
4 been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier?	☐	☑

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

	YES	NO
5 Medical staff membership or clinical privileges at any hospital or health care institution?	☐	☑
6 DEA registration?	☐	☑

C) Since you last renewed your Colorado license, have you

	YES	NO
7 had any felony or misdemeanor charges, or any traffic citations involving drugs or alcohol, brought against you?	☐	☑
8 illegally or excessively used any controlled substance, habit forming drug, prescription medication, or alcohol? You may answer NO if the behavior is already known to the Colorado Physician Health Program		
9 engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine safely and competently? You may answer NO if the behavior or conditions are already known to the Colorado Physician Health Program		



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

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

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

Questions 4 Attach copy of notification from insurance carrier

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

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

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

– OVER –

1999 RENEWAL INSURANCE VERIFICATION FORM

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

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

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

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

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

NOTE: Please supply your insurance policy number: ____________________________

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

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

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

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

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

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

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

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

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

MAKE CHECKS PAYABLE TO: COLORADO BOARD OF MEDICAL EXAMINERS

☐ **INACTIVE LICENSE FEE - $150** I wish to renew my license via INACTIVE STATUS (NOTE, this category is primarily intended for retired physicians and those practicing outside Colorado) Malpractice insurance is not required for inactive license holders **I understand that I may not practice medicine, including prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional $155.00. I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.**

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

[signature]	4/11/99	248-626-6603	248-684-2006
Signature of Physician	Date	Phone #	Fax ##

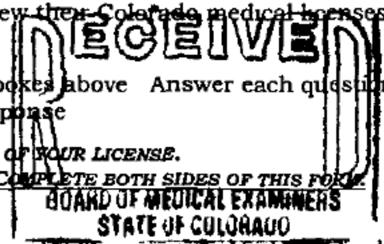
After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee, and 3) the Physician Survey (optional) in the enclosed return envelope Direct questions to **(303) 894-7719 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver, CO 80202-5140**

COLORADO BOARD OF MEDICAL EXAMINERS
2001 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #	LICENSE #
BOCK	PAMELA	A	Redacted	36747

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine with skill and safety to p[Redacted] "NO" if the behavior is already known to the Colorado Physician Health Program (CPHP)

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

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

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

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

2 DEA registration? ☐ YES ☑ NO

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

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

2001 LICENSE RENEWAL QUESTIONNAIRE AND INSURANCE VERIFICATION FORM

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

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

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

  ☐ COPIC ☐ Doctors Company ☐ St Paul ☐ Other (Specify)____________

  NOTE *Please supply your insurance policy number* ______________________

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

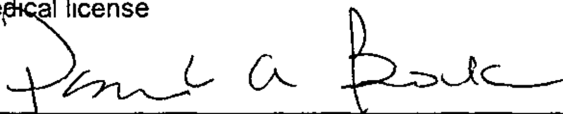
  ☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

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

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

MAKE CHECKS PAYABLE TO: COLORADO BOARD OF MEDICAL EXAMINERS

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



4/18/01

Signature of Physician **Date**

PAMELA A. BOCK 36747

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

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

Renewal - DR.0036747

Name	Pamela Anne Bock
Credential	DR.0036747

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 HPPP

Healthcare Professions Profiling Program ACTIVE status only:

All ACTIVE status licensees must maintain a Healthcare Professions Profile with current information. Please note that licensees are required to update their Healthcare Professions Profile within 30 days of changes or any reportable events. To access your HPPP account, please go to the HPPP Database by CLICKING HERE and enter your Login ID and Password for the HPPP system - these may be different from your User ID and password for this account in the Online Services system. Remember, it is your respons bility to maintain the accuracy of your Healthcare Profile within 30 days of any change. Failure to timely update your database may subject your license to disciplinary action.

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.

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.

KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

Review

Renewal - DR.0036747

Name	Pamela Anne Bock
Credential	DR.0036747

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.0036747

Name	Pamela Anne Bock
Credential	DR.0036747

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
108 South Frontage Road West, Suite 101	Vail	Colorado	81657	(970) 926-6340
50 Buck Creek Road, Suite 200	Avon	Colorado	81620	(970) 926-6340
377 Sylvan Lake Road, Suite 210	Eagle	Colorado	81631	(970) 926-6340

HPPP - MEDICAL Education and Training

Education and Training

51. School or Education Level:
Wayne State University School of Medicine

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

1987

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
Michigan	Active	1988

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
Vail Valley Medical Center	Admitting Privileges	Vail

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
Colorado Mountain Medical, PC	Affiliate	Vail	Colorado

HPPP GLOBAL - Business Ownership

Business Ownership

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

HPPP GLOBAL - Business Ownership if Yes

Business Ownership

64. Business Ownership:

Business Name	City	State
Colorado Mountain Medical, PC	Edwards	Colorado
Medical Group Ventures I	Avon	Colorado

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
Colorado Mountain Medical,PC	PO Box 4330	Avon	Colorado	81620	(970) 926-6340

HPPP GLOBAL - Employment Contracts

Employment Contracts

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

HPPP GLOBAL - Employment Contracts if Yes

Employment Contracts

68. Employment Contracts:

Entity Name	Length of Contract	Contract Position
Colorado Mountain Medical, PC	9/2008 - Present	Employee

HPPP GLOBAL - Disciplinary Actions

Disciplinary Actions

69. Have you ever had public disciplinary action taken against your license by any board or licensing agency in any state or country?
No

HPPP GLOBAL - Restrictions and Suspensions

Restrictions and Suspensions

71. Have you ever entered into any agreement or stipulation to temporarily cease your practice or had a board order issued restricting or suspending your license?
No

HPPP GLOBAL - Healthcare Facility Actions

Healthcare Facility Actions

73. Since September 1, 1990, have you had any final actions resulting in involuntary limitations or probationary status on or reduction, nonrenewal, denial, revocation or suspension of medical staff membership or clinical privileges at a hospital or healthcare facility? You are not required to report a precautionary or administrative suspension unless you resigned your medical staff membership or clinical privileges while the suspension was pending.
No

HPPP GLOBAL - Termination of Employment

Termination of Employment

75. Have you ever been terminated by an employer for a reason that would be considered a violation of your profession's practice law?
No

HPPP GLOBAL - DEA Registration

DEA Registration Surrender

77. Have you ever had to involuntarily surrender your United States Drug Enforcement Agency Administration Registration?
No

HPPP GLOBAL - Convictions

Convictions

80. Since you were issued a license to practice your profession in any state or country, have you had any final criminal conviction(s) or plea arrangement(s) resulting from the commission or alleged commission of a felony or crime of moral turpitude in any jurisdiction?
No

HPPP GLOBAL - Malpractice Claims

Malpractice Claims

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

HPPP GLOBAL - Malpractice Claims if Yes

Malpractice Claims

83. Malpractice Claims:

Year	State	Claim Type	Arbitrator, Mediator or Court
1994	Michigan	Settlement	

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:
03/17/2017

Review

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

Renewal - DR.0036747

Name	Pamela Anne Bock
Credential	DR.0036747

Fee Details

DR - Legal Defense Fund	$2.00
DR - PDMP Fee	$24.00
DR - Portal Fee	$1.50
DR - Renewal Fee Active	$218.50
DR- Peer Fee	$140.00
	$386.00

DR Renewal Attestation

The below attestations apply to your license's CURRENT status. You CANNOT 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. DR have Active and Inactive options, CDRH has Active only

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 engaged in any conduct or exhibited any behaviors that resulted in the following following OR that I have reported, or will report this information within 30 days to the Colorado Medical Board at dora_medicalboard@state.co.us or 303-894-7690.:

- An arrest, discipline, sanction or warning
- Loss or suspension of any license
- Termination or suspension of any license
- Endangering the safety of others
- A breach of fiduciary obligations
- A violation of workplace or academic conduct rules
- An impairment of your ability to practice in a safe, competent, ethical and professional manner
- Abusing or excessively using any habit forming drug, including alcohol, or any illegal or controlled substance resulting in any discipline for misconduct, failure to meet professional responsibilities, or affecting your ability to practice safely and competently
- Claiming the illegal use of a substance as a defense, in mitigation, or as an explanation for any conduct that impairs your ability to practice in a safe, competent, ethical, and professional manner

By renewing my license in ACTIVE status, I attest that I have NOT had an adverse action or administrative/judicial proceeding and I do not have a pending inquiry or investigation within the last two years by the following OR that I have reported, or will report this information within 30 days to the Colorado Medical Board at dora_medicalboard@state.co.us or 303-894-7690:

- A licensing authority - other than the Colorado Medical Board
- A government agency
- A court
- An employer
- An educational institution
- A professional organization
- In connection with an employment disciplinary or termination procedure

By renewing my license in ACTIVE status, I attest that: I have established and will continuously maintain professional liability insurance as required by 13-64-301, C.R.S.

All statuses click Next to proceed.

PDMP Renewal Attestation

By renewing your license in Active status, you agree with the following statement:

I attest that IF I maintain a current United States Drug Enforcement Agency (DEA) registration, I have registered an individual user account with Colorado's Prescription Drug Monitoring Program (PDMP) at https://colorado.pmpaware.net.

(If you have questions about registering or to check if you have registered, please email the PDMP Help Desk at pdmpinqr@state.co.us for assistance.)

Click Next to proceed.

AoE Renewal Update

Affidavit of Eligibility | Renewal Update of Information

1. Since you were originally licensed or since your last renewal (whichever was more recent) has the documentation you provided proving your legal status in the United States changed?

- If nothing has changed in your legal status or documentation, select "No"
- If your status has changed, or you need to update your documentation, select "Yes" to update your information

No

AoE Attestation

Affidavit of Eligibility | Section C: Attestation

By submitting this Affidavit of Eligibility (AoE) you are attesting that you have read and understand the statements below:

- 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 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.

96. Please enter today's date below:

03/17/2019

Healthcare Profile - Physician Introduction

Healthcare Professions Profile | Introduction

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.

Healthcare Profile - Location of Practice

Healthcare Professions Profile | Location of Practice

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

Yes

Healthcare Profile - Location of Practice if Yes

Healthcare Professions Profile | Location of Practice

98. Practice Locations:

Address	City	State	Zip Code	Phone Number
108 South Frontage Road West, Suite 101	Vail	Colorado	81657	(970) 926-6340
377 Sylvan Lake Road, Suite 210	Eagle	Colorado	81631	(970) 926-6340
50 Buck Creek Road, Suite 200	Avon	Colorado	81620	(970) 926-6340

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

99. School or Education Level:
Wayne State University School of Medicine

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

1987

Healthcare Profile - Other Licenses

Healthcare Professions Profile | Other Licenses

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

Healthcare Profile - Other Licenses if Yes

Healthcare Professions Profile | Other Licenses

102. Other Licenses:

State	License Status	Year Originally Issued
Michigan	Active	1988

Healthcare Profile - Board Certifications

Healthcare Professions Profile | Board Certifications

103. Do you hold any current Board Certifications?
Yes

Healthcare Profile - Medical Board Certifications if Yes

Healthcare Professions Profile | Board Certifications

104. Board Certifications:

Certification
Obstetrics and Gynecology

Healthcare Profile - Practice Specialties

Healthcare Professions Profile | Practice Specialties

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

Healthcare Profile - Medical Practice Specialties if Yes

Healthcare Professions Profile | Practice Specialties

106. Practice Specialties:

Specialty
Obstetrics and Gynecology

Healthcare Profile - Colorado Hospital Affiliations

Healthcare Professions Profile | Colorado Hospital Affiliations

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

Healthcare Profile - Colorado Hospital Affiliations if Yes

Healthcare Professions Profile | Colorado Hospital Affiliations

108. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
Vail Valley Medical Center	Admitting Privileges	Vail

Healthcare Profile - Other Facility and Out of State Hospital Affiliations

Healthcare Professions Profile | Other Facility and Out of State Hospital Affiliations

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

Healthcare Profile - Other Facility and Out of State Hospital Affiliations if Yes

Healthcare Professions Profile | Other State Hospital Affiliations

110. Other Healthcare Facility Affiliations:

Facility	Affiliation Type	City	State
Colorado Mountain Medical, PC	Affiliate	Vail	Colorado

Healthcare Profile - Business Ownership

Healthcare Professions Profile | Business Ownership

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

Healthcare Profile - Business Ownership if Yes

Healthcare Professions Profile | Business Ownership

112. Business Ownership:

Business Name	City	State
Colorado Mountain Medical, PC	Edwards	Colorado
Medical Group Ventures I	Avon	Colorado

Healthcare Profile - Employer

Healthcare Professions Profile | Employer

113. Do you have an employer in the profession in which you are licensed or are applying for a license?
Yes

Healthcare Profile - Employer if Yes

Healthcare Professions Profile | Employer

114. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
Colorado Mountain Medical,PC	PO Box 4330	Avon	Colorado	81620	(970) 926-6340

Healthcare Profile - Employment Contracts

Healthcare Professions Profile | Employment Contracts

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

Healthcare Profile - Employment Contracts if Yes

Healthcare Professions Profile | Employment Contracts

116. Employment Contracts:

Entity Name	Length of Contract	Contract Position
Colorado Mountain Medical, PC	9/2008 - Present	Employee

Healthcare Profile - Disciplinary Actions

Healthcare Professions Profile | Disciplinary Actions

117. Have you ever had public disciplinary action taken against your license by any board or licensing agency in any state or country?
No

Healthcare Profile - Restrictions and Suspensions

Healthcare Professions Profile | Restrictions and Suspensions

119. 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

Healthcare Profile - Healthcare Facility Actions

Healthcare Professions Profile | Healthcare Facility Actions

121. 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

Healthcare Profile - Termination of Employment

Healthcare Professions Profile | Termination of Employment

123. Have you ever been terminated by an employer for a reason that would be considered a violation of your profession's practice law?
No

Healthcare Profile - DEA Registration

Healthcare Professions Profile | DEA Registration

125. Have you ever had to involuntarily surrender your United States Drug Enforcement Agency Administration Registration?
No

Healthcare Profile - Convictions

Healthcare Professions Profile | Convictions

128. 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

Healthcare Profile - Malpractice Claims

Healthcare Professions Profile | Malpractice Claims

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

Healthcare Profile - Malpractice Claims if Yes

Healthcare Professions Profile | Malpractice Claims

131. Malpractice Claims:

Year	State	Claim Type	Arbitrator, Mediator or Court
1994	Michigan	Settlement	

Healthcare Profile - Malpractice Carrier Refusal

Healthcare Professions Profile | Malpractice Carrier Refusal

132. Have you been denied liability insurance, or has your liability insurance coverage been limited, restricted or terminated by the insurance carrier?
No

Healthcare Profile - Optional Narrative

Healthcare Professions Profile | Optional Narrative

134. Optional Narrative:

Healthcare Profile - Attestation

Healthcare Professions Profile | Attestation

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

- I am 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.

135. Submission Date:
03/17/2019

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
Pamela Anne Bock	Vail, CO 816574936

License Information

Some Physician Licensees have converted their Active Physician license to an Active Compact Physician License. This is noted below by the status label: Transferred to Compact Physician. If this status is present, then you may verify the license by searching for the license using the prefix "CDRH" and the Licensees Name on our Online Services page (https://apps.colorado.gov/dora/licensing/Lookup/LicenseLookup.aspx).

License Number	License Method	License Type	License Status	Original Issue Date	Effective Date	Expiration Date
DR.0036747	Original	Physician	Active	02/12/1998	05/01/2019	04/30/2021

Board/Program Actions

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

Generated on: 3/18/2019 9:46:53 AM