DIV. OF REGISTRATIONS

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

$569.00 mr 4/24/25 CC#

MAR26'12/00521
Application for Original License
**PHYSICIAN**
**Fee: $569**

**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.**

**Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to *State of Colorado*.**

## PART 1—APPLICANT INFORMATION

| | | | | |
|---|---|---|---|---|
| **Name:** Last: Melo | ☒ MD ☐ DO | First: Juliana | Middle: Roxo de Oliveira | Suffix: |
| **Previous Name(s):** N/A | | | | |
| **Social Security Number:** * Redacted | | **Date of Birth** (mm/dd/yyyy): Redacted | **Gender:** ☐ Male ☒ Female | |
| **Place of Birth** (city and state, or foreign country): Rio de Janeiro, Brazil | | | | |
| **Mailing Address:** PO Box, Street: 3119 Kaohinani Drive<br>*This is a* ☒ *Home* ☐ *Business* City, State, Zip: Honolulu, HI 96817 | | | | |
| **Daytime Telephone Number:** (808) 748-9657 | | **E-mail Address:** Redacted<br>*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 |
|---|---|---|---|---|
| L2 | Medical College of GA | 1120 15th St, Augusta, GA, 30912, | 2009/2008 | 2008 |

▶ 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) |
|---|---|---|---|
| L3 | University of Hawaii | Ob/Gyn | 2008/2012 |

**What is your specialty or specialties?** Obstetrics and 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 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:** 51181 **DATE ISSUED:** 4/25/12

APPLICANT NAME: Melo, Juliana

## 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 | Augusta, GA | 6/27/06 | Redacted |
| USMLE Step 2 | Aiken, SC | 7/26/07 | |
| USMLE Step 3 | Honolulu, HI | 2009 | |

gm

▶ 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? |
|---|---|---|---|---|---|
| temporary medical | Hawaii | MDR-5458 | 2008 | ☐ YES ☒ NO | ☒ YES ☐ NO |
| | | | | ☐ YES ☐ NO | ☐ YES ☐ NO |
| | | | | ☐ YES ☐ NO | ☐ YES ☐ NO |

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

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

| Application type | License Number | Month and year license issued |
|---|---|---|
| | | |
| | | |

## PART 5—MALPRACTICE INSURANCE CERTIFICATION

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

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

APPLICANT NAME: Melo, Juliana

## 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: Melo, Juliana

## PART 6—SCREENING QUESTIONS (Continued)

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

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

| Name of Facility | Date | Reason for Action |
|---|---|---|
| | | |
| | | |

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

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

| Date | Court | Violation | Penalty or Disposition |
|---|---|---|---|
| | | | |
| | | | |

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

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

Redacted

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: Melo, Juliana

## PART 6—SCREENING QUESTIONS (Continued)

10. Within the last five years, has any final judgment, settlement or arbitration award for medical malpractice been paid on your behalf or has any claim been filed which is still pending? ☐ YES ☒ NO
    - ► **If YES,** summarize below AND submit to the Board a completed malpractice Claims Information Form (attached) and a clinical narrative regarding your involvement in the case.

| Date | Name and Address of Insurance Company | Reason for Action |
|---|---|---|
| | | |
| | | |

11. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been canceled or rated at a higher premium due to past claims experience? ☐ YES ☒ NO
    - ► **If YES,** submit to the Board an explanation regarding the cancellation or increase in premiums of the insurance and verification directly from the insurance company to the Board.

## PART 7—SECURITY OF PATIENT MEDICAL RECORDS

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

## ATTESTATION

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

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

Juliana Melo
Signature of Applicant

3/1/12
Date

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

# REPORT OF PRACTICE HISTORY

(See instructions on following page)

| | Dates of Practice From mm/yyyy | To mm/yyyy | Facility Name | Address (Street & Number, City, State, ZIP) | Reference (Name and Title) | Nature of Practice |
|---|---|---|---|---|---|---|
| 1 | 07/2008 | 07/2012 current | University of Hawaii Obstetrics & Gynecology Residency Program | 1319 Punahou St., Rm 824 Honolulu, HI 96826 | Dr. Mark Hiraoka Program Director | Ob/Gyn Residency Program |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

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

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

Juliana Melo — Applicant Signature
Melo — Applicant Last Name (print)
3/1/12 — Date

2/2012

L6

** INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY **

| TIME RECEIVED | REMOTE CSID | DURATION | PAGES | STATUS |
|---|---|---|---|---|
| March 14, 2012 8:33:41 PM GMT+00:00 | 808-955-2174 | 50 | 1 | Received |

808-955-2174 10:49:34 a.m. 03-14-2012 1/1


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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 Juliana Roxo de Oliveira Melo
(Full Name of Applicant)

enrolled in Medical College of Georgia
(Full Name of School)

Augusta, Georgia (Location of School) on the 9 (Day) day of August (Month), 2004 (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 9 (Day) day of August (Month), 2004 (Year) and was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 09 (Day) day of May (Month), 08 (Year).

Signed and the college seal affixed

This 15 (Day) day of March (Month), 2012 (Year).

By Walter B. Mateer REGISTRAR
(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.

L2

Colorado Division of Registrations
**Office of Licensing—Medical**
1560 Broadway, Suite 1350
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 Juliana Roxo de Oliveira Melo
Full Name of Applicant

a graduate of Medical College of Georgia
Full Name of Medical/Osteopathic School

commenced postgraduate training at University of Hawaii Ob/Gyn Residency Program, 1319 Punahou St, Rm 824 Honolulu, HI 96826
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 July 1, 2008, ____ and satisfactorily completed or (will complete) such training on June 30, 2012.

This training consisted of 48 months 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 | LE |
|---|---|
| Obstetrics, Gynecology + Women's Health | 4 ye |

[redacted]

**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 Michael Aaronoff, MD for Mark Hiraoka, MD

Address 1319 Punahou St., #824, Honolulu, HI 96826

Phone Number (808) 203-6529 c/o Linell Goya Date 3/16/12

Signature Michael Aaronoff MD for Mark Hiraoka, MD
(Associate Program Director)

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

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

**No fee is required.**

| | | | | |
|---|---|---|---|---|
| **Physician Name:** Last: Melo | ☒ MD ☐ DO | First: Juliana | Middle: R. | Suffix: |
| **Social Security Number:** Redacted | | **Date of Birth** (mm/dd/yyyy): Redacted | | |
| **Address:** PO Box, Street: 3119 Kaohinani Drive<br>City, State, Zip: Honolulu, HI 96817 | | | | |
| **Medical School:** Medical College of Georgia | | **Date of Graduation:** May 2008 | | |

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

MAR 15 2012

Juliana Melo
Signature

3/1/12
Date

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

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

**Licensee/Applicant Full Legal Name**

| Last | First | Middle | Suffix |
|---|---|---|---|
| Melo | Juliana | Roxo de Oliveira | |

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

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

## AFFIDAVIT OF ELIGIBILITY

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

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

**Section A: LAWFUL PRESENCE in the United States**

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

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

| Government Issued Identification | Name of state agency or federal agency that issued the document | Full name as shown on driver's license or state/federal issued ID | License/ID Number | Expiration Date (mm/dd/yyyy) |
|---|---|---|---|---|
| ☐ Driver's license or permit | | | | |
| ☐ Government issued ID card | | | | |
| ☐ Valid U.S. military ID/common access card | | | | |
| ☐ Colorado Department of Corrections inmate ID | | | | |
| ☐ Tribal ID card | | | | |
| ☒ U.S. passport | U.S. Dept of State | Juliana Roxo de Oliveira Melo | 407322261 | 11/6/2016 |
| ☐ Certificate of Naturalization | | | | |

## Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)

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

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

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

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

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

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

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

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

| Issuing foreign country: | Passport Number: |
|---|---|
| | |

## Section C: ATTESTATION

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

Juliana Roxo de Oliveira Melo
Print Full Legal Name

Juliana R Melo
Signature (Full Name)

3/1/12
Date

# Renewal - DR.0051181

| | |
|---|---|
| Name | Juliana Roxo de Oliveira Melo |
| Credential | DR.0051181 |

## 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.

Redac

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.

Redac

**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.**

G. 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. Choose this option if your employer provides self insurance or trust coverage, or you are a Colorado State public employee covered under the Colorado Governmental Immunity Act.

KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

## DR Renewal HPPP

**Healthcare Professions Profiling Program ACTIVE status only:**

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

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

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

## Review

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

# 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 |
|---|---|
| Juliana Roxo de Oliveira Melo | Aurora, CO 80045 |

### 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.0051181 | Original | Physician | Expired | 04/25/2012 | 05/01/2013 | 04/30/2015 |

### Board/Program Actions

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

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