DIV. OF REGISTRATIONS
APR25'11/004B6

PAID
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366779

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

Application for Original License
PHYSICIAN
Fee: $522

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

PART 1—APPLICANT INFORMATION

Name: Last: GUIAHI	☒ MD ☐ DO	First: MARYAM	Middle: —	Suffix: —
Previous Name(s): —				
Social Security Number: * Redacted		**Date of Birth** (mm/dd/yyyy): Redacted	**Gender:** ☐ Male ☒ Female	
Place of Birth (city and state, or foreign country): IRAN				
Mailing Address: PO Box, Street: 850 AMSTERDAM AVENUE #6B *This is a* ☒ *Home* ☐ *Business* City, State, Zip: NEW YORK NY 10025				
Daytime Telephone Number: (708) 860-8929	**E-mail Address:** Redacted *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
LOYOLA STRITCH SCHOOL OF MEDICINE	MAYWOOD IL 60153	2001 - 2005	✓

▶ 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)	
LOYOLA UNIVERSITY MEDICAL CENTER	OBSTETRICS & GYNECOLOGY	2005 - 2009	✓

What is your specialty or specialties? OBSTETRICS & GYNECOLOGY

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

OFFICE USE ONLY LICENSE NUMBER: #50347 DATE ISSUED: 07/20/2011

APPLICANT NAME: MARYAM QUTAHI

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	ILLINOIS	5/2007 6/2003	Redacted
USMLE STEP 2	ILLINOIS	10/2004	
USMLE STEP 2 CK	ILLINOIS	4/2005	
USMLE STEP 3	ILLINOIS	5/2007	

► 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	ILLINOIS	125049258	2005	☐ YES ☒ NO	☐ YES ☒ NO
	NEW YORK	252572-1	2009	☐ 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: CLAIM EXEMPTION C RULE 220

APPLICANT NAME: MARYAM GHIAHI

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: MARYAM GUIAHI

PART 6—SCREENING QUESTIONS (Continued)

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

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

Name of Facility	Date	Reason for Action

7. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law? Note: You must respond YES even if the charge(s) or action was ultimately dismissed, pardoned, or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs. ☐ YES ☒ NO

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

Date	Court	Violation	Penalty or Disposition

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

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

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: MARYAM GUIAHI

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
4/23/2006	LOYOLA UNIVERSITY PHYSICIAN FOUNDATION, ILLINOIS	SEE ATTACHED
1/27/2009	LOYOLA UNIVERSITY PHYSICIAN FOUNDATION, ILLINOIS	SEE ATTACHED

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

ATTESTATION

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

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

Signature of Applicant

4-17-2011
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
7/2005	6/2009	LOYOLA UNIVERSITY MEDICAL CENTER	2160 S. FIRST AVE MAYWOOD IL 60153	[illegible] RADIOLOGY DIRECTOR	RADIOLOGIST
7/2009	01/2011	COLUMBIA UNIVERSITY MEDICAL CENTER	622 W. 168TH ST NEW YORK NY 10032	CAROLYN [illegible] DIVISION DIRECTOR	HOSPITAL PRACTICE

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

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

Applicant Signature | GUPTA | Applicant Last Name (print) | 4-17-2011 | Date

1/2011

L6

Dora
Department of Regulatory Agencies

Division of Registrations
Rosemary McCool
Director

Colorado Medical Board
Marschall S. Smith
Program Director

John W. Hickenlooper
Governor

Barbara J. Kelley
Executive
Director

M E M O R A N D U M

TO: Colorado Board of Medical Examiners

FROM: Jan Seewald, Administrative Assistant

SUBJECT: **Maryam Guiahi, M.D.**
(Special Physician Applicant)

Date: June 29, 2011

Dr. Guiahi responded "yes" to the following application question:

#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?"

Dr. Guiahi reported two civil malpractice cases that are currently pending.

Case # 1

COLORADO MEDICAL BOARD
CLAIMS INFORMATION FORM

Applicant: Complete this form for each liability or malpractice claim identified in the application Screening Question regarding malpractice.

MARYAM GUAITI — 708-860-8926
Name of Physician — Business Telephone Number

850 AMSTERDAM AVENUE #603 — NEW YORK NY 10025
Address — City, State, ZIP

1. On a separate sheet of paper, type your full name and provide a clinical narrative regarding each malpractice case(s) / allegations. Include name of patient, age, sex, date of occurrence, and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description, which includes all of the facts requested above. Simply stating that the charges were dismissed is inadequate, more detail must be provided.

2. Indicate your position in case, i.e., intern, resident, primary doctor, etc. INTERN

3. Case was filed against: ☒ Individual doctor ☐ Group ☒ Hospital

   List names of other doctors and/or hospitals also named in the suit: DR. ERIK MUNASIFAT
   LOYOLA UNIVERSITY MEDICAL CENTER

4. Plaintiff's Attorney and Telephone: MARY CUNNINGHAM 312-327-6358

5. Is the claim pending? ☒ YES ☐ NO

6. Was there a judgment or settlement? ☐ YES ☒ NO

7. What was the amount and date of the judgment or settlement? N/A

8. What amount was attributable to you, your insurance company, or your employer? N/A

Pending case

I certify that the information I have provided is correct to the best of my knowledge.

Signature

4-19-2011
Date

Case #2

COLORADO MEDICAL BOARD
CLAIMS INFORMATION FORM

Applicant: Complete this form for each liability or malpractice claim identified in the application Screening Question regarding malpractice.

MARYAM GUIAITH — Name of Physician

708-860-8929 — Business Telephone Number

850 AMSTERDAM AVENUE #6B — Address

NEW YORK NY 10025 — City, State, ZIP

1. On a separate sheet of paper, type your full name and provide a clinical narrative regarding each malpractice case(s) / allegations. Include name of patient, age, sex, date of occurrence, and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description, which includes all of the facts requested above. Simply stating that the charges were dismissed is inadequate, more detail must be provided.

2. Indicate your position in case, i.e., intern, resident, primary doctor, etc. RESIDENT

3. Case was filed against: ☑ Individual doctor ☑ Group ☑ Hospital

   List names of other doctors and/or hospitals also named in the suit: DR. RENATO POTKUL, DR. DONNA SMITH, DR. DARBY MURPHY, LOYOLA UNIVERSITY MEDICAL CENTER

4. Plaintiff's Attorney and Telephone: BOB BARKER, 312-663-9600

5. Is the claim pending? ☑ YES ☐ NO

6. Was there a judgment or settlement? ☐ YES ☒ NO

Pending Case

7. What was the amount and date of the judgment or settlement? N/A

8. What amount was attributable to you, your insurance company, or your employer? N/A

I certify that the information I have provided is correct to the best of my knowledge.

Signature

4-19-2011 — Date

LOYOLA MEDICINE

We also treat the human spirit.®

PHYSICIAN: Maryam Guiahi, M.D.

NUMBER OF SUITS SINCE JULY 1, 1995: Two

1. Claimant: Mona Kutak Date of Loss: 4/23/06 Status: Open
   Court Number: 10 L 000791
   ☐ Closed with indemnity payment Amount $_____ Date of Payment_____
   ☐ Closed no payment

2. Claimant: Bridget Pappas Date of Loss: 1/27/09 Status: Open
   Court Number: 10L 014218
   ☐ Closed with indemnity payment Amount $_____ Date of Payment_____
   ☐ Closed no payment

3. Claimant _____ Date of Loss_____ Status: ☐ Open ☐ Closed
   Court Number: _____
   ☐ Closed with indemnity payment Amount $_____ Date of Payment_____
   ☐ Closed no payment

4. Claimant _____ Date of Loss_____ Status: ☐ Open ☐ Closed
   Court Number: _____
   ☐ Closed with indemnity payment Amount $_____ Date of Payment_____
   ☐ Closed no payment

5. Claimant _____ Date of Loss_____ Status: ☐ Open ☐ Closed
   Court Number: _____
   ☐ Closed with indemnity payment Amount $_____ Date of Payment_____
   ☐ Closed no payment

The above is based on records that date back only to July 1, 1995. We are unable to verify any information prior to that date. This is not a verification of insurance coverage.

Representative's Name: MIKE FAGAN Title: SR. CLAIMS MANAGER, CLAIMS MANAGEMENT

Telephone : 708/216-8150 Date: March 10, 2011

Signature: Mike Fagan

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for

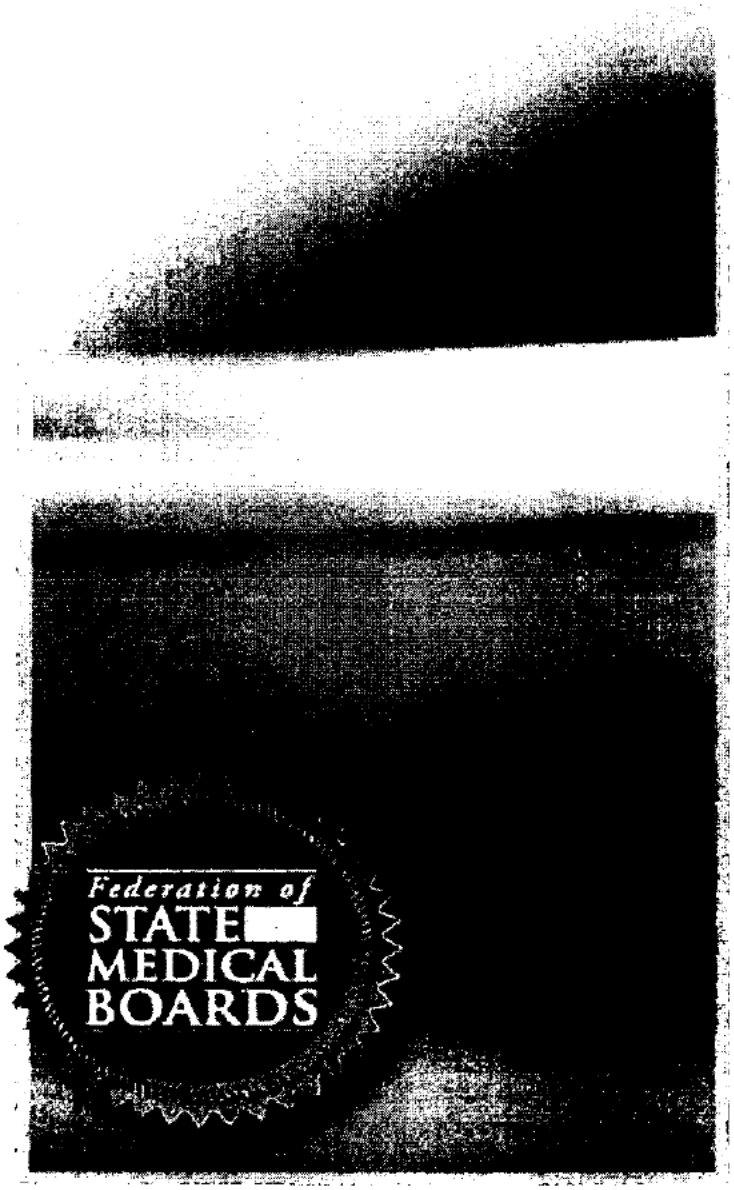
Name: **Maryam Guiahi**

Social Security: Number: **XXX-XX-**[Redacted]

Date of Birth: **October 19, 1979**

FID#: **214687303**

Recipient: **CO - Colorado Medical Board**



ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: Your board may wish to review the unresolved items below marked by an "X"
Please review the Credentials Analysis report for further details on the unresolved items

Medical Professional Name: Maryam Guiahi
Date of Birth: Redacted
Social Security Number:
FID: 214687303

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

IV. Medical Education

A. Pre-medical Schools
B. Medical Schools

Loyola University of Chicago Stritch School of Medicine

1. Medical Education Form
2. Medical Education L2
3. Medical Education Dean's Letter
4. Medical Education Transcript
5. Medical Education Diploma

C. Fifth Pathway Program
D. ECFMG Certification

V. Graduate Medical Education

Loyola University Medical Center

X 1. GME Form
2. GME Completion Certificate

New York and Presbyterian Hospital - Columbia Campus

1. GME Completion Certificate

VI. Licensure Examination History

A. FSMB Exams

End of report for: Maryam Guiahi

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Section I

FCVS Reports

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name: **Maryam Guiahi**
Documentation: Valid Original Passport

Variation Of Name: **Maryann Guiahi**
Explanation: This was a mistake made by my medical school. My name is uncommon and they used a more common version.

Gender: Female
Date of Birth: Redacted
Place of Birth: IRAN, ISLAMIC REPUBLIC OF
Social Security Number: XXX-XX-Redacted
FID: 214687303
Physical Description: Height: 5 ft. 7 in.
Weight: 125 lbs.
Eye Color: Brown
Hair Color: Brown

Contact Information

Mailing Address: 850 AMSTERDAM AVE APT 6B
NEW YORK, NY 10025-5135
UNITED STATES

Permanent Address: 3 OAKRIDGE DR
HUNTINGTON, NY 11743-5130
UNITED STATES

Telephone Numbers: Primary: (708) 860-8929 7088929
Secondary: (212) 305-4938
Fax: N/A
Other: N/A

Premedical Education

(Provided by Applicant. Not verified with the primary source)

Institution 1: **Cornell University**

Address: Ithaca, NY 14853
UNITED STATES

Dates of Attendance: 08/1998 To 06/2001

Degree conferred/issued: Bachelor of Science

Medical Education

Medical School:

Address: **Loyola University of Chicago Stritch School of Medicine**
2160 South First Avenue
Maywood, IL 60153
UNITED STATES

Dates of Attendance: 07/30/2001 To 06/10/2005

Date Degree Conferred: 06/12/2005

Degree conferred/issued: Doctor of Medicine

Unusual Circumstances: Redacted

Leave of Absence/Extension:

Probation:

Disciplined:

Negative Reports:

Limitations:

ECFMG

There are none identified.

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **Loyola University Medical Center**
Address: 2160 South First Avenue
Maywood, IL 60153
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/27/2005 To 06/26/2006
Successfully Completed: Yes
Accreditation: ACGME

Training Level: 2 - 4
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/27/2006 To 06/26/2009
Successfully Completed: Redacted
Accreditation: ACGME

Unusual Circumstances: Redacted
Leave of Absence/Extension:
Probation:
Disciplined:
Negative Reports:
Limitations:

Board Action

A report of the results from a search of the Board Action Data Bank is enclosed.

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Licensure Examination

FSMB Transcript USMLE Step 1	Date: 06/2003
FSMB Transcript USMLE Step 2 CK	Date: 10/2004
FSMB Transcript USMLE Step 2 CS	Date: 04/2005
FSMB Transcript USMLE Step 3	Date: 05/2007

Redacted

End of report for Maryam Guiahi FID: 214687303

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures. The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Medical Professional Identification

Medical Professional Name: **Maryam Guiahi**
Date of Birth: Redacted
Social Security Number:
FID: **214687303**

Omissions

Omission 1:

Section of Profile: **GME**
Omission: **The Verification of Graduate Medical Education Form completed by Loyola University Medical Center does not indicate the official institution title of the signatory.**
Action Taken: **FCVS has verified at the ACGME website that the signatory is the Program Director.**

✓

Discrepancies

There are no discrepancies identified.

Miscellaneous Information

Miscellaneous 1:

Section of Profile: **GME**
Miscellaneous: **The applicant and Loyola University Medical Center do not report the same program type from 06/2005 to 06/2006.**
Action Taken: **FCVS does not follow up on program type based on the definition of a resident per ACGME (A physician at any level of GME in a program accredited by the ACGME is considered a resident).**

✓

End of report for: Maryam Guiahi

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Maryam Guiahi**
Date of Birth: Redacted
Social Security Number:
FID#: **214687303**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
8/2001	06/2005	Medical Education Record	Loyola University of Chicago Stritch School of Medicine,2160 South First Avenue Maywood, IL 60153 UNITED STATES		
7/2005	06/2009	GME Record	Loyola University Medical Center,2160 South First Avenue Maywood, IL 60153 UNITED STATES		

End of report for Maryam Guiahi

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Section II

FSMB and Other Reports

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FPDC | FEDERATION PHYSICIAN DATA CENTER

Board Action Clearance Report

May 06, 2011

Attn: Tracy Bevers
FCVS
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: May 06, 2011
FSMB Batch Number: BQ1905284

The following is a report of the search results from the Board Action Data Bank as of May 06, 2011 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of May 06, 2011

Name	DOB	School	Yr/Grad	Provider ID
Maryam Guiahi	Redacted	014050	2005	201543
Reporting State/Agency:				
Date of Order:				

License History

Licensing Entity
NEW YORK

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

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Section III

Identity

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I, hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my reques

Nunya Torres
Notary Public, State of New York
No. 01TO6191591
Qualified in Manhattan County
Commission Expires August 18, 2012

Qualified in Manhattan County
Commission Expires August 18, 2012

Applicant's Signature (must be signed in the presence of a notary)

Applicant's Printed Last Name

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

Date of Signature (must correspond to date of notarization)

State of New York County of New York

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 7th day of March, 2011.

Notary Public Signature: Nunya Torres

My Notary Commission Expires: 8/18/2012

201543

Section IV

Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Loyola University of Chicago Stritch School of Medicine

Address Line 1:
2160 South First Avenue

Address Line 2:
Building 120 Room 220

City: Maywood **State/Province:** IL **Zip Code (Postal Code):** 60153
Country: US

If name of institution was different when this individual attended, please note this name below:

Premedical Education:
Years of education required for admission to your medical school: 4
Credential/degree presented by the applicant for admission to your medical school: BS

Enrollment and Participation: Our records indicate that Giviahi Maryann
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 166 weeks of medical education on the following dates: From: 07/30/01 (Month Day Year) To: 06/10/05 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 06/21/2005 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

SEAL VERIFIED

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.

Name: Julie Steinecker
Signature: Julie Steinecker
Title: Assistant Registrar
Date of Signature: 03/18/2011 **Phone:** (708) 216-3222
Fax: (708) 216-8151 **Email:**

201543 894 9 214687303

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? Redacted

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved:

Personal/Family	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Academic remediation	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Health	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Financial	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Participation in joint degree *Program (e.g., MD/PhD)*	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Participation in non-research special study (e.g., fellowship, international experience)	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Participation in non-degree research	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Other	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Redacted

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

Academic Probation	From (Mo/Yr)____/____	To (Mo/Yr)____/____
Probation for unprofessional conduct/behavioral	From (Mo/Yr)____/____	To (Mo/Yr)____/____
Probation for other reason	From (Mo/Yr)____/____	To (Mo/Yr)____/____

Please specify a reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Redacted

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university?

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements:

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-3000 FAX(817)040-5099

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Maryam Guiahi

Loyola University of Chicago Stritch School of Medicine

Unusual Circumstances

Redacted

Did you have any interruption(s) or extension(s) in your medical education?

Were you ever placed on probation?

Were you ever disciplined or placed under investigation?

Were any negative reports for behavioral reasons ever filed by instructors?

Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?

End of report for Maryam Guiahi

PROVIDED BY APPLICANT

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

Loyola University

Stritch School of Medicine

Chicago

Ad Majorem Dei Gloriam

Upon certification by the faculty that the requirements prescribed have been duly fulfilled, Loyola University, by virtue of the authority vested in the Board of Trustees, has conferred upon

Maryam Gulahi

the degree of

Doctor of Medicine

with all the honors and privileges pertaining to this degree.

In witness thereof this diploma is given at Chicago, Illinois, on the twelfth day of June, in the year of Our Lord two thousand and five bearing the signatures of the President and of the Dean and the seal of the University.

SEAL
VERIFIED

I hereby certify that this is a true copy of the original document presented to me this 18th day of March, 2011

Julie Steinecker
Assistant Director
Registration & Records

894

201543

Section V

Graduate Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Loyola University Medical Center

Address: Obstetrics and Gynecology
Maywood, IL 60153

Attention: **Program Director**

Affiliated University: Loyola Universtiy Medical Center

Verification For:

Name: **Guiahi, Maryam**

DOB: Redacted

Individual's Name on Record (If different from above): ____

Program Participation:

Important:
Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 1 (e.g., 1, 2, 3, etc.)
☒Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: Obstetrics & Gynecology
From: 06/27/2005 **To:** 06/26/2006
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: 2-4 (e.g., 1, 2, 3, etc.)
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: Obstetrics & Gynecology
From: 06/27/2006 **To:** 06/26/2009
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: _____
From: / / **To:** / /
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ..... Redacted
2. Was this individual ever placed on probation? .....
3. Was this individual ever disciplined or placed under investigation? .....
4. Were any negative reports for behavioral reasons ever filed by instructors? .....
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?

Please explain any "Yes" response from above:

_____

_____

Certification:

ELECTRONIC SEAL VERIFIED

Affix your institutional seal in this space. If

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Kimberly Kenton, M.D.

Signature: Kimberly Kenton, MD

Institutional Title of Signatory: _____
(e.g., Program Director)

Date of Signature: 03/28/2011

Tel: 708/216-2170 Fax: 708/216-9435 E-Mail: kkenton@lumc.edu

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name: Maryam Guiahi
Loyola University Medical Center
Obstetrics and Gynecology

Unusual Circumstances

Redacted

Did you have any interruption(s) or extension(s) in your medical education?

Were you ever placed on probation?

Were you ever disciplined or placed under investigation?

Were any negative reports for behavioral reasons ever filed by instructors?

Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?

End of report for Maryam Guiahi

PROVIDED BY APPLICANT

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

Loyola University Affiliated Hospitals

Sponsored by

Foster G. McGaw Hospital

Loyola University Medical Center

LOYOLA

1870

AD · MAJOREM · DEI · GLORIAM

This Certifies That

Maryam Guiahi, M.D.

has faithfully and successfully completed the duties and obligations of

Residency in Obstetrics and Gynecology

Completed June 26, 2009

In Witness Whereof we hereby subscribe our signature and affix our seal.

Department Chairman

Program Director

Designated Institution Official

Dean Stritch School of Medicine

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

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

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

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

Complete this form and mail directly to:

Federation of State Medical Boards
PO Box 619850
Dallas, TX 75261-9850

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

No fee is required.

Physician Name: Last: GUIAHI	☒ MD ☐ DO	First: MARYAM	Middle: —	Suffix: —
Social Security Number: Redacted		**Date of Birth** (mm/dd/yyyy): Redacted		
Address: PO Box, Street: 850 AMSTERDAM AVE #6B City, State, Zip: NEW YORK NY 10025				
Medical School: LOYOLA STRITCH SCHOOL OF MEDICINE		**Date of Graduation:** 6-2005		

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 3 1 2011

Signature

3-18-20
Humayun J. Chaudhry, D.O., FACP
President and CEO
Date

COLUMBIA UNIVERSITY
College of Physicians and Surgeons

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
622 West 168th Street
New York, NY 10032

Colorado Board of Medicine
Office of Licensing- Medical
1560 Broadway, Suite 1350
Denver, CO 80202

April 19, 2011

Dear Colorado Board of Medicine:

I currently reside outside of Colorado and claim exemption C set forth in rule 220. I understand that before I engage in any medical practice in Colorado, I must obtain the required insurance or an acceptable equivalent.

Sincerely,

Maryam Guiahi MD
Department of Obstetrics & Gynecology
622 W. 168th Street PH 16-69
New York, NY 10032
(212) 305-4938

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

Licensee/Applicant Full Legal Name

Last	First	Middle	Suffix
GUIAHI	MARYAM		

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

Professional or Occupational License/Certification/Registration type applying for: PHYSICIAN

AFFIDAVIT OF ELIGIBILITY

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

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

Section A: LAWFUL PRESENCE in the United States

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

Section B: SECURE AND VERIFIABLE DOCUMENTS. Complete 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	UNITED STATES DEPARTMENT OF STATE	MARYAM GUIAHI	427662087	08-06-2017
☐ Colorado Department of Corrections inmate ID				
☐ Valid military ID/common access card				

Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)

☐ **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, B-2, H-1B, etc.)	Date of entry (mm/dd/yyyy)	Until date (mm/dd/yyyy)

☐ **Valid I-766 (Employment Authorization Card)**

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

☐ **Valid I-551 (Resident Alien or Permanent Resident Card)**

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

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.

MARYAM GUIATI

Print Full Legal Name

Signature (Full Name)

4-19-2011

Date

COLUMBIA UNIVERSITY
College of Physicians and Surgeons

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
622 West 168th Street
New York, NY 10032

Colorado Board of Medicine
Office of Licensing- Medical
1560 Broadway, Suite 1350
Denver, CO 80202

May 12, 2011

Dear Colorado Board of Medicine:

I currently reside and practice outside of Colorado and claim exemption D set forth in rule 2:20. I understand that before I engage in any medical practice in Colorado, I must obtain the required insurance or an acceptable equivalent.

Sincerely,

Maryam Guiahi MD
Department of Obstetrics & Gynecology
622 W. 168th Street PH 16-69
New York, NY 10032
(212) 305-4938

Renewal - DR.0050347

Name	Maryam Guiahi
Credential	DR.0050347

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.

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

Review

Renewal - DR.0050347

Name	Maryam Guiahi
Credential	DR.0050347

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.0050347

Name	Maryam Guiahi
Credential	DR.0050347

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
12631 E. 17th Ave	Aurora	Colorado	80045	(303) 724-2038

HPPP - MEDICAL Education and Training

Education and Training

51. School or Education Level:
Loyola University of Chicago Stritch School of Med

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

2005

HPPP GLOBAL - Other Licenses

Other Licenses

53. Have you ever held, or do you currently hold any other licenses in this profession from any other state, country or province?
No

HPPP GLOBAL - Board Certifications

Board Certifications

55. Do you hold any current Board Certifications?
Yes

HPPP - MEDICAL Board Certifications if Yes

Board Certifications

56. Board Certifications:

Certification
Obstetrics and Gynecology

HPPP GLOBAL - Practice Specialties

Practice Specialties

57. Do you have a practice specialty in which you are appropriately trained and actively practicing?
No

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
University of Colorado Hospital	Faculty	Aurora

HPPP GLOBAL - Other Hospital Affiliations

Other Health Care Facilities and Out of State Hospital Affiliations

61. Do you have a current affiliation with any healthcare facility or a non-Colorado hospital?
No

HPPP GLOBAL - Business Ownership

Business Ownership

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

HPPP GLOBAL - Employer

Employer

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

HPPP GLOBAL - Employer if Yes

Employer

66. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
Stephanie Teal	12631 E. 17th Ave	Aurora	Colorado	80045	(303) 724-2025

HPPP GLOBAL - Employment Contracts

Employment Contracts

67. Do you have a contract with any business whose mission relates to healthcare services or products where the value is greater than $5000 annually?
No

HPPP GLOBAL - Disciplinary Actions

Disciplinary Actions

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

HPPP GLOBAL - Restrictions and Suspensions

Restrictions and Suspensions

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

HPPP GLOBAL - Healthcare Facility Actions

Healthcare Facility Actions

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

HPPP GLOBAL - Termination of Employment

Termination of Employment

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

HPPP GLOBAL - DEA Registration

DEA Registration Surrender

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

HPPP GLOBAL - Convictions

Convictions

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

No

HPPP GLOBAL - Malpractice Claims

Malpractice Claims

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

No

HPPP GLOBAL - Malpractice Carrier Refusal

Malpractice Carrier Refusal

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

No

HPPP GLOBAL - Optional Narrative

Optional Narrative

86. Optional Narrative:

University of Colorado Department of Obstetrics and Gynecology 2016 Resident Faculty Appreciation Award University of Colorado School of Medicine 2016 Foundations of Doctoring: Golden Stethoscope OB/GYN Nominee Association of Professors of Gynecology & Obstetrics 2016 APGO/CREOG Academic Scholars and Leaders Program Physicians for Reproductive Health 2014 Kenneth J. Ryan MD Memorial Scholarship Award University of Colorado Department of Obstetrics and Gynecology 2013 Resident Faculty Appreciation Award Council on Resident Education in Obstetrics and Gynecology and Association of Professors of Gynecology and Obstetrics 2012 Annual Meeting 2012 Oral Presentations- Second Place Loyola University Medical Center Department of Obstetrics and Gynecology 2009 Resident Teacher of the Year Chicago Gynecologic Society 2009 Resident Paper Competition- Third Place Chicago Gynecologic Society 2007 Resident Paper Competition- Second Place Loyola University Medical Center 2006 Magis Star Award Loyola Stritch School of Medicine 2005 Wensinger Obstetrics Research Scholarship Loyola University Medical Center Department of Surgery 2004 Surgical Honors Society

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.0050347

Name	Maryam Guiahi
Credential	DR.0050347

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 any inquiry, investigation or administrative/judicial proceeding by the followingfollowing 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
- A government agency
- 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:
03/12/2019

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
12631 e. 17th ave	Aurora	Colorado	80045	(303) 724-2038

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

99. School or Education Level:
Loyola University of Chicago Stritch School of Med

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

2005

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
New York	Expired	2011
Illinois	Expired	2005

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
University of Colorado Hospital	Faculty	Aurora

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?
No

Healthcare Profile - Business Ownership

Healthcare Professions Profile | Business Ownership

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

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
University of Colorado	12631 e. 17th ave	Aurora	Colorado	80045	(303) 724-2038

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?
No

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?
No

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:
03/12/2019

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
Maryam Guiahi	Denver, CO 80218

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.0050347	Original	Physician	Active	07/20/2011	05/01/2019	04/30/2021

Board/Program Actions

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

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