COLORADO STATE BOARD OF MEDICAL EXAMINERS

RECEIVED
MAR 14 2005 VA
DIVISION OF REGISTRATIONS

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE FEE $425.00

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

1 a. Name: Last	First	Middle	Degree	1b. Social Security Number
HERTZ	MICHAEL	ISRAEL	MD	

2. Other names (i.e. maiden name)- indicate if none.	What is your speciality(s)
NONE	OB/GYN

3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE, Address provided is, by law, public information.)

☐ Home
☒ Business/MAILING 298 EAST SALISBURY ST

City	State	Zip	Country
PITTSBORO	NC	27312	USA

e-mail address: NOT APPLICABLE

4. Telephone Number: (Area Code) Day	Evening	5. Date of Birth: Mo/Day/Year	Place of Birth
269- 649-5301			HIGHLAND PARK, MI

6. Sex (Male) Female

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

$425.00 28
78932

8.a. List name/address of the school where medical degree was received.
Request an original L2 Form (Certificate of Medical Education – Certificate must be sent directly from the school to this office.)

Name of School	Address and Zip	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Wayne State University School of Medicine	54E EAST CANFIELD AVE DETROIT, MI 48201	9/72	5/76

8 b. If this is an international medical school, please provide the country where the school is physically located:

9. List name of licensing exam(s): ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam. Request certification of scores from examining agency be sent directly to this office.

Exam	Location	Date	Result
NBME Part I	MICHIGAN	6-11-74	
NBME Part 2	MICHIGAN	9-23-75	
NBME Part 3	MICHIGAN	3-9-77	

10. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs?
☒ Yes If Yes, provide information below.
☐ No

Name of facility	Specialty	Period of attendance From (Mo/Yr)	Period of attendance To (Mo/Yr)
SINAI HOSPITAL OF DETROIT DETROIT, MI	OB/GYN	3/76	3/80

11. Are you Board Certified by either the American Board of Medical Specialties or the American Osteopathic Association?
☒ Yes If Yes, list certification information.
☐ No American Board of Obstetrics and Gynecology 12-9-83

L1A

Official Use Only	License # 42527	Date 4/27/05 LIS
Revised 10/99	Fee $	Date:

12. Are you now or have you ever been licensed to practice medicine in any state, territory, district or country? Include temporary licenses and educational permits. Request verification from each to be sent to the Colorado Board.

☒ Yes If Yes, provide information below.
☐ No

State or country	License #	Dates of Practice in this jurisdiction	
		Issue Date	Expiration Date
MICHIGAN	4301037973	6-21-77	1-31-07
FLORIDA	ME 35436	10-1-79	1-31-07

13. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic board of any complaint, investigation or inquiry, which is **currently pending?** NO

☐ Yes 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.

No

State	Date	Charge	Disposition

14. Has **any disciplinary action** ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity? (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question.

☐ Yes. If Yes, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board, as well as a narrative regarding the action taken.

☒ No

State	Date	Charge	Disposition

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

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

☒ No

Agency	Date	Reason

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

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

☒ No

Agency	Date	Reason for denial

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

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

☒ No

Agency	Date	Reason

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

☐ **Yes** If Yes, summarize below AND request hospital to submit a report directly to the Board regarding the suspensions etc. Also submit your narrative regarding the suspension of privileges.

☒ **No**

Name of facility	Date	Reason for action

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

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

☒ **No**

Date	Court	Violation	Penalty or disposition

20. Within the last five years, have you engaged in any behavior or suffered any mental, physical or cognitive health condition that has affected or might affect your ability to practice medicine safely and competently? You may answer NO if the behavior or condition is already known to the Colorado Physician Health Program ("CPHP"). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

Yes If Yes, submit an explanation to the Board regarding the behavior or condition. Be specific as to date of occurrences, the type of behavior or condition involved, and what if anything has been done to correct the behavior or condition. Any discharge summaries, evaluations, or reports must be submitted directly to the Board from the source.

No

21. Within the last five years, have you illegally or excessively used any controlled substance, habit-forming drug, prescription medication, or alcohol? You may answer NO if your use of such substances is already known to the Colorado Physician Health Program ("CPHP"). "Known to CPHP" means that you have informed CPHP of your use of such substances and you are complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

Yes If Yes, submit to the Board, an explanation regarding the offense/situation. Be specific as to date of occurrences, the type of behavior involved, and what if anything has been done to correct the behavior. Must also submit copies of the DUI or DWAI court records and police reports.

No

22. Within the last five years,

- have you been diagnosed or treated for bipolar disorder, severe major depression, schizophrenia or other psychotic disorder?
- Have you been diagnosed with or treated for a neurological illness or sleep disorder that disturbs your cognition, behavior or motor function?
- Have you undergone a cardiac bypass procedure?

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

Yes If Yes, submit explanation to the Board regarding the diagnosis or disorder(s). Be specific as to date of occurrences, the type of disorder involved, and what if anything has been done to treat the disorder. Any discharge summaries, evaluations, or reports must be submitted directly to the Board from the source.

No

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

☐ **Yes** If Yes, summarize below AND submit to the Board a completed malpractice claims form and a clinical narrative regarding your involvement in the case.

☒ **No**

Date	Name and address of Insurance Company	Reason for Action

24. 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.** 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.

☒ **No**

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

EXEMPTION CLAIMED: D

L1C

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

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

I understand that if my application does not have any issues which require Board review my application will be administratively approved as soon as it becomes complete unless I indicate otherwise below.

☒ Process my application for review now.

☐ Process my application for review on or after (list month and year):_____

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

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

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

Signature

2/25/05
Date

RETURN THIS APPLICATION TO:

COLORADO BOARD OF MEDICAL EXAMINERS
1560 BROADWAY, SUITE 1350
DENVER CO 80202-5140

L1D

To: Colorado Board of Medical Examiners
From: Michael I. Hertz, M.D.

Re: Internship Training Dates

I attended medical school during the following time period:

9/72 - 5/76	Medical School: Wayne State University School of Medicine Detroit, MI

My internship and residency training dates are as follows:

3/15/76 – 3/14/80	Internship and Residency, OB/GYN: Sinai Hospital of Detroit Detroit, MI

There is an overlap of my medical education and training dates. I was permitted to begin my internship training at the Sinai Hospital of Detroit prior to obtaining my MD degree, in May of 1976. I have completed all the course requirements for medical school graduation by February of 1976. Sinai Hospital of Detroit was part of the teaching program at Wayne State University School of Medicine. By beginning this program in March, I did not have to participate in the national matching program. Also, since I began my training early, this arrangement benefited the hospital by ensuring that they would fill this training position.

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS **Department of Regulatory Agencies**
1560 Broadway, Suite 1350
Denver, Colorado 80202-5146
Phone (303) 894-7800
Fax (303) 894-7693
V/TDD (303) 894-7880
www.dora.state.co.us/medical

Division of Registrations

REPORT OF PRACTICE HISTORY

	Facility Name	Address and Zip	Reference (name and title)	Dates of Practice From-To	Nature of Practice
1.	SINAI HOSPITAL OF DETROIT	6767 West Outer Drive Detroit, MI 48201	ALFRED I. SHERMAN, MD RESIDENCY DIRECTOR	3/76-3/80	INTERN/RESIDENT OB/GYN
2.	PRIVATE PRACTICE, MICHAEL HERTZ, MD.	SOUTHFIELD, MI (NOW CLOSED)	N/A - PRIVATE PRACTICE	3/80-11/80	OB/GYN Physician
3.	N/A VACATION	N/A - VACATION - MOVE TO FLORIDA	N/A - VACATION - MOVE TO FLORIDA	11/80-12/80	N/A - VACATION
4.	PRIVATE PRACTICE, MICHAEL HERTZ, MD	BOCA RATON, FL (NOW CLOSED)	N/A - PRIVATE PRACTICE	1/81-11/82	OB/GYN Physician
5.	HENRY FORD HOSPITAL	2799 W. Grand Blvd Detroit, MI 48202	BRUCE PARKER, MD CHAIRMAN, DEPT OB/GYN	11/82-7/83	OB/GYN Physician
6.	PRIVATE PRACTICE, MICHAEL HERTZ, MD	BOCA RATON, FL (NOW CLOSED)	N/A - PRIVATE PRACTICE	7/83-6/97	OB/GYN Physician
7.	BRONSON WOMEN'S SERVICE Bronson Methodist Hospital	601 John St Kalamazoo, MI 49007	SCOTT LARSON, MD CHIEF MEDICAL OFFICER	7/97-10/04	OB/GYN Physician
8.	Vicksburg Women's Healthcare/ Bronson Methodist Hospital	13322 N. Blvd, #A Vicksburg, MI 49097	SCOTT LARSON, MD CHIEF MEDICAL OFFICER	11/04-PRESENT	OB/GYN
9.					
10.					

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

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

Michael Hertz

SIGNATURE

HERTZ

PRINT LAST NAME

2/25/05

DATE

L6

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1350
Denver, Colorado 80202-5146
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Department of Regulatory Agencies

Division of Registrations

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that MICHAEL ISRAEL HERTZ
FULL NAME OF APPLICANT

enrolled in WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE
FULL NAME OF MEDICAL SCHOOL

DETROIT, MI. on the 11th day of September 19 72
LOCATION OF MEDICAL SCHOOL

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

The undersigned certifies that the records of this institution show that he/she attended this institution beginning on the 11th day of September, 1972 and was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 23rd day of May, 1976.

Signed and the college seal affixed

This 31st day of MARCH 2005

By Jaesta Jones
MRS. JAESTA JONES SUPERVISOR

RECEIVED
MAR 15 2005
RECORDS & REGISTRATION OFFICE
WSU SCHOOL OF MEDICINE

NOT VALID WITHOUT SCHOOL SEAL
NOTE TO REGISTRAR:
IF NO SCHOOL SEAL, PLEASE INDICATE ABOVE, NEXT TO SIGNATURE OF PRESIDENT/SECRETARY/DEAN.

L2

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1350
Denver, Colorado 80202 5146
Phone (303) 894-7800
Fax (303) 894-7693
V/TDD (303) 894-7830
www.dora.state.co.us/medical

Department of Regulatory Agencies

Division of Registrations

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

THIS SECTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO THE FACILITY WHERE POSTGRADUATE TRAINING WAS RECEIVED AND/OR COMPLETED

This certifies that MICHAEL ISRAEL HERTZ
FULL NAME OF APPLICANT

a graduate of WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE
FULL NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in SINAI HOSPITAL OF DETROIT
NAME AND ADDRESS OF FACILITY

TO BE COMPLETED BY THE PROGRAM DIRECTOR OF THE FACILITY FOR ACGME/AOA POSTGRADUATE TRAINING IN THE UNITED STATE OR CANADA. PLEASE TYPE OR PRINT.

on 3/15/76 and satisfactorily completes such training on 3/14/80.

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

List type and length of training.

ROTATION	LENGTH OF ROTATION

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

YES X NO ____

IF NO, PLEASE ATTACH AN EXPLANATION.

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

DIRECTOR GME Mary F. Euth

ADDRESS 4201 St. Antoine 2B-UHC Detroit, MI 48201

PHONE NUMBER (313) 745-5147 DATE 4/20/05

SIGNATURE Mary F. Euth

L3

Jeb Bush
Governor

FLORIDA DEPARTMENT OF
HEALTH

John O. Agwunobi, M.D., M.B.A., M.P.H.
Secretary

FLORIDA CERTIFICATION PART - I

March 28, 2005

Colorado Board of Medical Examiners
1560 Broadway, Suite 1300
Denver, CO 80202-5140

RE: Michael Israel Hertz, M.D.

To Whom It May Concern:

This is to certify the records of the Department of Health indicating the following for the above noted Medical Doctor:

MEDICAL LICENSE NUMBER:	**ME 35436**
CERTIFICATION:	**10/11/1979**
EXPIRATION DATE:	**01/31/2007**
CURRENT STATUS OF LICENSE:	**Clear, Active**
BOARD ACTION:	**Refer to Part II provided by Central Records Unit (850)245-4121**

To expedite the verification process, the above format is the standard format prepared for all Medical Doctors. The information above is the only verification document provided by this Department. A copy of this request is being forwarded to the Agency Clerk for research and response regarding the existence of any derogatory information.

Tammy Chester
Staff Assistant
(850) 245-4444 Ext. 3561

Jeb Bush
Governor

FLORIDA DEPARTMENT OF HEALTH

John O. Agwunobi, M.D., M.B.A., M.P.H.
Secretary

Florida Certification - Part II

STATE: CO DATE: March 29, 2005

RE: Michael Israel Hertz

A search of the Department of Health computer files revealed the following complaint history on the above-referenced individual.

CURRENT COMPLAINT INFORMATION

Medical License Number: ME35436

*Case Open/Pending Complaint(s): None

**Case Closed/Probable Cause Found: None

***Closed Medical Malpractice Claims: 3

Case Dismissed/Probable Cause Not Found: 199300410 - Insufficient evidence to prosecute.

State Certification processor might receive a request from a State Board requesting this information If the licensee should call regarding this information refer the caller to the Consumer Services Unit for Charlene Willboughby
Cases that are Dismissed without a finding of Probable Cause are CONFIDENTIAL AND MAY NOT BE RELEASED TO ANYONE. The licensee may or may not have been notified of dismissed cases. If this information is released, it could result in your state not receiving confidential information in the future.

If you have any questions, please contact Central Records Unit at (850) 245-4121.

*To obtain information on pending complaints, please write to Joy Moore, DOH, Bureau of Health Care Practitioner Regulation-Legal, Prosecution Services Unit, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3265, telephone (850) 414-8126 or fax (850) 414-1989.

**Documentation enclosed / will follow by regular mail.

***To obtain information on closed medical malpractice claims, please write to Florida Department of Financial Services, Document Processing Office, Post Office Box 5320, Tallahassee, Florida 32314-5320. If you have any questions, please contact the Department of Financial Services at (850) 413-3149 or fax (850) 488-3429.
10

STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH

LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

MAR 2 8 2005 JB

DIVISION OF REGISTRATIONS

VERIFICATION OF LICENSURE

MICHIGAN BOARD OF MEDICINE

VERIFICATION OF LICENSURE AS OF 03/23/2005

COLORADO BOARD OF MEDICAL EXAMINERS
1560 BROADWAY STE 1300
DENVER CO 80202-5140

NAME: Michael Israel Hertz

SSN:

ADDRESS: 13322 N Boulevard Suite-A
Vicksburg MI 49097

BIRTHDATE:

TYPE: Medical Doctor

ORIGINAL DATE: 06/21/1977

LICENSE NUMBER: 4301037973 **STATUS:** Active

EXPIRATION DATE: 01/31/2007

OBTAINED BY: Examination

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

CAROLYN F. PARKINSON

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1350
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Phone (303) 894-7800
Fax (303) 894-7693
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Department of Regulatory Agencies

Division of Registrations

DISCIPLINARY ACTION REPORT

PLEASE COMPLETE ALL BLANKS ON THIS FORM AND MAIL TO:

FEDERATION OF STATE MEDICAL BOARDS
PO Box 619850
DALLAS, TX 75261-9850

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

*****NO FEE REQUIRED*****

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAR 10 2005

DALE L. AUSTIN
SENIOR VICE PRESIDENT
AND CHIEF OPERATING OFFICER

The Federation of State Medical Boards maintains a national databank of all disciplinary action taken by state licensing boards and/or other credentialing agencies. To complete your application we must have a report from the Federation. Please note: an unfavorable report does not automatically disqualify you from licensure in Colorado.

NAME MICHAEL ISRAEL HERTZ

ADDRESS c/o MLS, 298 EAST SALISBURY ST

CITY, STATE AND ZIP CODE PITTSBORO NC 27312

DATE OF BIRTH

SOCIAL SECURITY NUMBER

MEDICAL SCHOOL WAYNE STATE UNIVERSITY

DATE OF GRADUATION 5-23-76

I hereby authorize and request that the Federation of State Medical Boards of the United States Inc. provide a disciplinary history to the State of Colorado Board of Medical Examiners

Signature

3-9-05
Date

L7

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

RESPONSE TO SELF-QUERY

A. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name:	HERTZ, MICHAEL ISRAEL
Gender:	MALE
Date of Birth:	
Other Name(s) Used:	
Organization Name:	
Organization Type:	
Other, as Specified:	
Home or Work Address:	298 EAST SALISBURY ST.
City, State, ZIP:	PITTSBORO, NY 27312
Country:	
Social Security Numbers (SSN):	
Individual Taxpayer Identification Numbers (ITIN):	
Federal Employer Identification Numbers (FEIN):	
National Provider Identifiers (NPI):	
Drug Enforcement Administration (DEA) Numbers:	
Unique Physician Identification Numbers (UPIN):	
Professional School(s) & Year(s) of Graduation:	WAYNE STATE UNIVERSITY SCHOOL OF MEDICIN 1976
Occupation/Field of Licensure (Code):	PHYSICIAN (MD) (010)
State License Numbers, State of Licensure:	ME35436, FL
Other, as Specified:	
Specialty:	OBSTETRICS & GYNECOLOGY (50)
Occupation/Field of Licensure (Code):	PHYSICIAN (MD) (010)
State License Numbers, State of Licensure:	4301037973, MI
Other, as Specified:	
Specialty:	OBSTETRICS & GYNECOLOGY (50)

B. PAYMENT INFORMATION

Payment Type:	CREDIT CARD
Account Number:	XXXXXXXXXXXX2821
Expiration Date:	08/2005
Transaction Date:	03/14/2005
Transaction Number:	5500000036603577
Total Charge:	**$8.00**

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

C. SEARCH RESULT

Based on the subject identification information provided by you in Section A above, a search of the NPDB has located the following 2 report(s).

Type of Report	Report Number
Medical Malpractice Payment Report	1119943060101000
Medical Malpractice Payment Report	5500000003876268

Recipients should verify that the subject identified in Section A is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the NPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

Drug Enforcement Administration (DEA) Numbers:

Hospital Affiliation(s):

C. INFORMATION REPORTED

Date of Report: 11/07/1994
Act/Omission Code: TREATMENT: DELAY IN TREATMENT (665)
Date of Act/Omission: 09/14/1992
Payment Date: 09/02/1994
Multiple or Single Payment: SINGLE
Amount of This Payment: $45,000.00
Total Amount of Judgment or Settlement:
Payment Result of: SETTLEMENT
Number of Practitioners for Whom Payment Is Made: 1
Relationship of Entity to the Practitioner: INSURANCE COMPANY
Date of Judgment/Settlement: 08/31/1994
Adjudicative Case Number: CL 94-2170 AB
Adjudicative Body Name: CIRCUIT COURT, 15TH JUDICIAL CIRCUIT, BROWARD COUNTY, FL
Court File Number:

Reporter's Description of the Act or Omission: A 33-YEAR-OLD FEMALE OUTPATIENT UNDERWENT A DILATION AND CURETTAGE, HYSTEROSCOPY AND LAPAROSCOPY FOR ABNORMAL VAGINAL BLEEDING. THE SAME DAY SHE WAS ADMITTED TO THE HOSPITAL WITH ABDOMINAL PAIN. THE PATIENT UNDERWENT EXPLORATORY SURGERY AT WHICH TIME A SMALL PERFORATION OF THE SMALL BOWEL WAS IDENTIFIED AND RESECTED. SHE ALLEGED A DELAY IN DIAGNOSIS AND TREATMENT OF THE BOWEL PERFORATION.

Reporter's Description of the Judgment or Settlement: A TOTAL SETTLEMENT OF $45,000 WAS MADE ON BEHALF OF DR. HERTZ WITHOUT ADMISSION OF LIABILITY.

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

Hospital Affiliation(s):

C. INFORMATION REPORTED

Date of Report: 10/10/1996
Act/Omission Code: OBSTETRICS: FAILURE TO IDENTIFY/TREAT FETAL DISTRESS (555)
Date of Act/Omission: 11/17/1991
Payment Date: 09/24/1996
Multiple or Single Payment: SINGLE
Amount of This Payment: $30,000.00
Total Amount of Judgment or Settlement:
Payment Result of: SETTLEMENT
Number of Practitioners for Whom Payment Is Made: 1
Relationship of Entity to the Practitioner: INSURANCE COMPANY
Date of Judgment/Settlement: 09/13/1996
Adjudicative Case Number: 93-6113AB
Adjudicative Body Name: 15TH JUDICIAL CIRCUIT - PALM BEACH COUNTY
Court File Number:

Reporter's Description of the Act or Omission: THIS 26 YEAR OLD FEMALE ALLEGED THAT OUR MEMBER FAILED TO COME TO THE HOSPITAL AFTER IT IS ALLEGED THERE WAS FETAL DISTRESS. IT IS QUESTIONABLE AS TO WHAT INFORMATION WAS RELAYED TO DR. HERTZ BY THE NURSING STAFF. THE PLAINTIFF LATER DELIVERED A STILL BORN BABY.

Reporter's Description of the Judgment or Settlement: FULL AND FINAL SETTLEMENT ACHEIVED ON BEHALF OF DR. HERTZ IN THE AMOUNT OF $30,000.00 WITHOUT AN ADMISSION OF LIABILITY. 91-16419-01/02-045

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

DCN: 5500000036603577
Process Date: 03/14/2005

C. SEARCH RESULT

Based on the subject identification information provided by you in Section A above, a search of the HIPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section A is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Section 1128E of the Social Security Act. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the HIPDB is confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

Department of Regulatory Agencies (DORA) - LicenSure 2.07 - [DR43527: Hertz, Michael Israel - Application Checklist]

File Utilities Reports Window Help

License Type: Physician **Complete Date:** 04/29/2005 **Status:** Approved

Application Dates

Received: 03/17/2005

Fee Received: 03/15/2005

Release Score:

Exempt: Not Exempt **Referred to SPA:** 00/00/0000

Internal Control Approval: 04/29/2005 **User Id:** RXHERNANDE

Time Limit: 03/17/2006

Time Limit Override: 00/00/0000 **User Id:**

Internal Exam Approval: 00/00/0000 **Expiration:** 00/00/0000

External Exam Approval: 00/00/0000 **Expiration:** 00/00/0000

Internal Comments: **Inc. Ltr. Sent:** 04/04/2005

The NPDB/HIPDB reports indicated two civil malpractice cases that were settled over five years ago. This application will not be a "Special Application".

Jan Seawald 04/28/05

Payment History

827	Personal Check	425
CO	Original License Fee	$325.00
CO	Peer Fee	$100.00
	Total Payments:	**$425.00**

OK	NA	Notes	User ID	Checked On	Application Checklist
Licensure					
☑	☐	☑	JLCARTER	04/29/2005	Certificate of Medical Education (Form L2)
☑	☐	☐	JLCARTER	04/04/2005	Completed application if "yes" answer to questions 12-24, Board review required.
☑	☐	☐	JLCARTER	04/04/2005	Copy of Birth Certificate or passport

Ready Row 1 of 1 JLCARTER 09/23/2005 11:1

Start Inbox - M... LICENSE ... Message ... Departm... 11:15

TO: Colorado Board of Medical Examiners
FROM: Michael Israel Hertz, M.D.

I currently reside outside of Colorado, and claim exemption D. I do not engage in any patient care whatsoever in the state of Colorado. I understand that before I engage in any medical practice in Colorado, I must obtain the required insurance or an acceptable equivalent.

Michael Israel Hertz, M.D.

Date: 2/25/05

The Secretary of State of the United States of America
hereby requests all whom it may concern to permit the citizen/national
of the United States named herein to pass without delay or hindrance
and in case of need to give all lawful aid and protection.

Le Secrétaire d'Etat des Etats-Unis d'Amérique
prie par les présentes toutes autorités compétentes de laisser passer le citoyen/ressortissant des Etats-Unis titulaire du présent passeport, sans délai ni difficulté et, en cas de besoin, de lui accorder toute aide et protection légitimes.

El Secretario de Estado de los Estados Unidos de América por el presente solicita a las autoridades competentes permitir el paso del ciudadano o nacional de los Estados Unidos aquí nombrado, sin demora ni dificultades, y en caso de necesidad, prestarle toda la ayuda y protección lícitas

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE/FIRMA DEL TITULAR

NOT VALID UNTIL SIGNED

PASSPORT
PASSEPORT
PASAPORTE

USA

UNITED STATES OF AMERICA

Type / Type / Tipo: P
Code / Code / Código: USA
Passport No. / No. du Passport / No. de Pasaporte: 200573508

Surname / Nom / Apellidos
HERTZ

Given names / Prénoms / Nombres
MICHAEL ISRAEL

Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento
06 NOV 1949

Sex / Sexe / Sexo: M

Place of birth / Lieu de naissance / Lugar de nacimiento
MICHIGAN, U.S.A.

Date of issue / Date de délivrance / Fecha de expedición
18 May 1999

Authority / Autorité / Autoridad
National Passport Center

Date of expiration / Date d'expiration / Fecha de caducidad
17 May 2009

Amendments / Modifications / Enmiendas
See Page 24

P<USAHERTZ<<MICHAEL<ISRAEL<<<<<<<<<<<<<<<<<<<<
200573508 6USA4911106M0905172<<<<<<<<<<<<<<06

Renewal - DR.0043527

Name	Michael Israel Hertz
Credential	DR.0043527

Fee Details

Renewal Fee	$2.00
Renewal Fee	$334.00
Renewal Fee	$3.00
Renewal Fee	$18.00
Renewal Fee	$144.00
	$501.00

DR Renewal Questionnaire

PART I: MANDATORY RENEWAL QUESTIONNAIRE

You must answer "YES" or "NO" to each question below. If you answer "YES" to a question, you must mail a copy of this questionnaire and a detailed explanation to include dates, amounts and contact information, to the Board for each "YES" answer within **thirty (30) days** of submitting your renewal. If the matter has already been disclosed to the Board, you must send a letter to the Board providing the case number and identifying information. If no documentation is received, a case may be opened and a complaint issued for an explanation of each "YES" answer.

Mail all documentation to:

Colorado Medical Board, ATTN: Renewal, 1560 Broadway, Suite 1350, Denver, CO 80202

SECTION A: SINCE YOU LAST RENEWED YOUR COLORADO MEDICAL LICENSE:

1. Have you been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any health care facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law, whether involuntary or in lieu of investigation?

No

2. Have you surrendered a license or other authorization to practice medicine in another state or jurisdiction, or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?

If you answer YES to question number 2, you must provide a detailed summary of the events which led to the charges or citation. Include a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.

No

3. Have you, in any state, been denied medical liability insurance, or has your medical liability insurance coverage been limited, restricted or terminated by action of the insurance carrier?

If you answer YES to question number 3, you must provide a copy of the notification from the insurance carrier and a summary of the events which led to the action by the carrier. If you do not have a copy of the notification, contact the insurance carrier to obtain one.

No

4. Have you had any felony or misdemeanor charges of any kind brought against you? Have you had any traffic citations involving drugs or alcohol brought against you? Regardless of the case disposition, you must answer YES if you have been charged.

If you answer YES to question number 4, you must provide a detailed summary of the events which led to the charges or citation. Include a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.

No

5. **For question 5, you must answer YES** if any of these actions are currently pending, or if you have withdrawn or failed to proceed with an application for these items.

Has your medical staff membership or clinical privileges at any hospital or healthcare facility been involuntarily or in lieu of investigation reduced, limited, placed on probation, not renewed or relinquished, or been denied, revoked or suspended?

If you answer YES to questions 5, you must provide a detailed summary to the Board of the conduct/allegation upon which action was taken.

No

6. **For question 6, you must answer YES** if any of these actions are currently pending, or if you have withdrawn or failed to proceed with an application for these items.

Has your DEA registration been involuntarily or in lieu of investigation reduced, limited, placed on probation, not renewed or relinquished, or been denied, revoked or suspended?

If you answer YES to questions 6, you must provide a detailed summary to the Board of the conduct/allegation upon which action was taken. And you must include the notification from the DEA. If you do not have a copy of the notification, contact the DEA to obtain a copy.

No

SECTION B IN THE LAST TWO YEARS:

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

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

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

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

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

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

PART 2: MANDATORY ATTESTATION

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

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

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

Please select only 1 item below.

F. I am a physician who is not engaged in the practice of medicine in the State of Colorado.

DR Renewal HPPP

Healthcare Professions Profiling Program ACTIVE status only:

REMINDER:

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

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

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

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

Review

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

Renewal - DR.0043527

Name	Michael Israel Hertz
Credential	DR.0043527

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.