STATE OF MICHIGAN
THIRD CIRCUIT COURT

SUMMONS AND RETURN OF SERVICE

CASE NO.

BREECH, MICHELE, As Next Friend ,
Hon. Isidore Torres 03/23/2009

09-006715-NI

COURT
ADDRESS: 2 WOODWARD AVENUE, DETROIT, MICHIGAN 48226

COURT
TELEPHONE NO. (313) 224- received 4/30/09

THIS CASE ASSIGNED TO JUDGE: [illegible] Bar Number: 28455

PLAINTIFF	DEFENDANT
[illegible]	NORTHWEST WOMES CARE DBA 3990 John R - One Harper/Brush Detroit, MI 48201

PLAINTIFF'S ATTORNEY

McKeen, [illegible]
[illegible]
645 Griswold St Ste 4200
Detroit MI 48226-4210
[redacted]

CASE FILING FEE	JURY FEE	
Paid	Paid	
ISSUED	**THIS SUMMONS EXPIRES**	**DEPUTY COUNTY CLERK**
3/23/2009	06/22/2009	Pamela Oliver

*This summons is invalid unless served on or before its expiration date. Cathy M. Garrett – Wayne County Clerk

NOTICE TO THE DEFENDANT: In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. YOU HAVE 21 DAYS after receiving this summons to file an answer with the court and serve a copy on the other party or to take other lawful action (28 days if you were served by mail or you were served outside this state).
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.

☐ There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the complaint.
☐ A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in _____ Court.
☐ There is no other pending or resolved action within the jurisdiction of the family division of circuit court involving the family or family members of the parties.
☐ An action within the jurisdiction of the family division of the circuit court involving the family or family members of the parties has been previously filed in _____ Court.

The docket number and assigned judge of the civil/domestic relations action are:

Docket no.	Judge	Bar no.

The action ☐ remains ☐ is no longer pending.

I declare that the complaint information above and attached is true to the best of my information, knowledge, and belief.

Date _____ Signature of attorney/plaintiff _____

SEAL OF THE CIRCUIT COURT OF WAYNE COUNTY MICHIGAN

COMPLAINT IS STATED ON ATTACHED PAGES. EXHIBITS ARE ATTACHED IF REQUIRED BY COURT RULE.

If you require special accommodations to use the court because of disabilities, please contact the court immediately to make arrangement.

MAY 26 2015

(12/2014)

Regular Mailing Address	Courier Delivery Address
STATE BOARD OF MEDICINE P.O. BOX 2649 HARRISBURG, PA 17105-2649 717-783-1400/717-787-2381 Email: st-medicine@pa.gov	STATE BOARD OF MEDICINE 2601 NORTH THIRD STREET HARRISBURG, PA 17110

APPLICATION FOR A TEMPORARY LICENSE

***To Qualify for a Temporary License, You Must Hold an Active Medical License in Another Jurisdiction.**

If you hold an Osteopathic License, please use the application under the Osteopathic Board.

CHECK THE CIRCUMSTANCE UNDER WHICH YOU ARE SEEKING A TEMPORARY LICENSE:

- ☐ Teaching and demonstrating advanced medical and surgical techniques. Applicant must be sponsored by a medical training facility licensed or authorized to do business in this Commonwealth.
- ☐ Participating in a medical or surgical procedure necessary for the well being of a specified patient or patients. Applicant must be sponsored by a health care facility licensed or authorized to do business in this Commonwealth and must work in collaboration with a medical doctor holding a license without restriction in this Commonwealth.
- ☒ Practicing medicine and surgery in a camp or resort for no more than three months. Adequate arrangements must be made for back-up medical care if the physician is unable to continue to serve as a medical doctor for the camp or resort.
- ☐ Attending to the medical and surgical needs of a person or persons visiting the Commonwealth for a brief period of time.
- ☐ Serving as a short-term replacement of a doctor of medicine employed by the Federal Government in a National Health Service Corps Clinic, pursuant to the Project U.S.A. arrangements.
- ☐ Other:

REQUIRED DOCUMENTS

1.	Submit a $45.00 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt.
2.	Arrange for the hospital, health care facility, employer or camp to complete page 3 of the application. **This form must contain an original signature.**
3.	Arrange for the collaborating or back-up physician to complete and submit page 4 of the application indicating in detail the acceptance of specific responsibilities. **This form must contain an original signature.**
4.	Submit a letter from an insurance company which verifies malpractice insurance coverage at this facility during the dates of practice in Pennsylvania. This letter must include the policy number. If self-insured, provide a statement to this effect.
5.	Contact the State Board where you are currently practicing and request a letter of good standing to be sent directly to the Board. This letter of good standing must be sent directly to the Pennsylvania Board.
6.	Attach a current Curriculum Vitae listing **all** periods of employment or unemployment (i.e., child rearing, research, etc.) from graduation from medical school to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.
7.	The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. Child Abuse Continuing Education Providers Information can be found here.

MAY 1 2 2015

IMPORTANT INFORMATION
Please allow 60 days for processing of this application.
You may not practice in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Medicine has issued you a license.
Failure to provide sufficient information and supporting documents may result in a processing delay or the return of your application.

(12/2014)

HOSPITAL, HEALTH CARE FACILITY, EMPLOYER OR CAMP VERIFICATION FORM

PENNSYLVANIA HEALTH CARE FACILITY, CAMP OR ORGANIZATION

NAME OF ORGANIZATION:	Camp Stone		
ADDRESS:	Street: 2145 Deer Run Drive		
City: Sugar Grove	State: PA	ZIP: 16350	

NAME OF APPLICANT:	Last: Puder	First: Karoline	Middle: Suzanne
DATES OF SERVICE FOR THE APPLICANT:	From: Month/Day/Year: 6/01/2015	To: Month/Day/Year: 08/31/2015	

LIST IN DETAIL THE ANTICIPATED PRACTICE OF THE APPLICANT. THIS MUST INCLUDE THE TYPE OF PRACTICE AND FREQUENCY OF PRACTICE.

Diagnosis and treatment of common ambulatory illnesses including but not limited to suturing and any other procedure physician is skilled and comfortable performing.

PRINTED NAME:	Randi Mashmoor		
TITLE:	Assistant to the Director		
SIGNATURE:	Randi Mashmoor		
DATE:	Month: March	Day: 3	Year: 2015

MAY 1 2 2015

(12/2014)

COLLABORATING/BACK-UP PHYSICIAN FORM

COLLABORATING/BACK-UP PHYSICIAN'S NAME:	Last: Matlaga	First: Roman	Middle:
LICENSE NUMBER OF COLLABORATING/BACK-UP PHYSICIAN:	OS008779L		
NAME OF TEMPORARY LICENSE APPLICANT:	Last: Puder	First: Karoline	Middle: Suzanne
DATES YOU WILL SERVE AS THE COLLABORATING/BACK-UP PHYSICIAN:	**From**: Month/Day/Year: 06/01/2015	**To**: Month/Day/Year: 08/31/2015	

PENNSYLVANIA HEALTH CARE FACILITY, CAMP OR ORGANIZATION

NAME OF ORGANIZATION:	Camp Stone		
ADDRESS:	Street: 2145 Deer Run Drive		
City: Sugar Grove	State: PA	ZIP: 16350	

I AGREE TO SERVE AS THE COLLABORATING/BACK-UP PHYSICIAN FOR THE ABOVE NAMED APPLICANT IN THE PERFORMANCE OF THE FOLLOWING LISTED DUTIES:

Evaluation and treatment of common ailments at camp including illness, injury and suturing. Splinting and stabilization of a suspected broken or strained extremity. Appropriate prescribing of medications including antibiotics and pain medication. To refer to specialist if a medical problem is beyond his/her expertise or ability.

SIGNATURE OF COLLABORATING/ BACK-UP PHYSICIAN:	[redacted]		
DATE:	Month: March	Day: 03	Year: 2015

MAY 1 2 2015

Curriculum Vitae

Karoline Suzanne Puder, MD

Address:

Office:
3990 John R
Detroit, MI 48201

Home:
[redacted]
Southfield, MI 48034

Date of Birth: [redacted]

Medical School:
Mount Sinai School of Medicine
New York, NY
Graduation – June 1988

Residency:
Mount Sinai Hospital
Obstetrics and Gynecology
New York, NY
July 1988-June 1992

Fellowship:
Hutzel Hospital/Wayne State University
Maternal-Fetal Medicine
Detroit, MI
July 1992-June 1994

Attending Physician:
Wayne State University
Department of Obstetrics and Gynecology
Maternal-Fetal Medicine
Detroit, MI
July 1994-present

MAY 1 2 2015

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY): 4/27/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER A. M. Skier Agency 209 Main Avenue Hawley, PA 18428	CONTACT NAME: AMSkier Agency, Inc. PHONE (A/C, No, Ext): 570-226-4571; 800-245-2666 FAX (A/C, No): 570-226-1105 E-MAIL ADDRESS: amskier@amskier.com
INSURED Camp Stone 2145 Deer Run Road Sugar Grove, PA 16350	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A: Markel Insurance Company INSURER B: INSURER C: INSURER D: INSURER F:

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS MADE OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC	☐	☐				EACH OCCURRENCE $ DAMAGE TO RENTED PREMISES (Ea occurrence) $ MED EXP (Any one person) $ PERSONAL AND ADV INJURY $ GENERAL AGGREGATE $ PRODUCTS - COMP/OP AGG $ $
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS	☐	☐				COMBINED SINGLE LIMIT $ BODILY INURY (Per person) $ BODILY INURY (Per accident) $ PROPERTY DAMAGE $ Deductible: $
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $	☐	☐				EACH OCCURRENCE $ AGGREGATE $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	☐				WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT $ E.L. DISEASE - EACH EMPLOYEE $ E.L. DISEASE - POLICY LIMIT $
	Professional Liability	☐	☐	8502CY4190020	11/1/2014	11/1/2015	1,000,000 per occurance; 5,000,000 aggregate

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHILCES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

For the dates of service while at camp: 6/1/2015 - 8/31/2015.

CERTIFICATE HOLDER

Dr. Karoline S. Puder
Camp Stone
[redacted]
Sugar Grove, PA 16350

MAY 12 2015

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE6

HENRY M. SKIER
President

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the DataBank

P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb.hrsa.gov

PUDER, KAROLINE SUZANNE - SELF-QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: PUDER, KAROLINE SUZANNE
Date of Birth: [redacted] **Gender:** FEMALE
Work Address: 22880 COVENTRY WOODS LN, SOUTHFIELD, MI 48034-2108
Social Security Number: [redacted] **NPI:** 1790722288
License: PHYSICIAN (MD), 4301059142, MI, OBSTETRICS & GYNECOLOGY
Professional School(s): MOUNT SINAI SCHOOL OF MEDICINE OF NEW YORK UNIVERSITY (1988)

B. PAYMENT INFORMATION

Credit Card Information: [redacted]
NPDB Charge: $5.00* **NPDB Bill Reference Number:** N36829373
* Each charge will appear separately on your credit card statement.
Transaction Date: 04/22/2015 **Additional Paper Copies Requested:** 0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 04/22/2015

The following report types have been searched:

Medical Malpractice Payment Report(s):	**Yes, See Below**	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are enclosed for restricted/limited use as prescribed by statutes listed on the preceeding cover page.

THE DETROIT MEDICAL CENTER

MEDICAL MALPRACTICE PAYMENT
Basis for Action: - FAILURE TO TREAT

Initial Action: - SETTLEMENT **Date of Action:** 08/21/2013
DCN: 5500000085219573

THE DETROIT MEDICAL CENTER

MEDICAL MALPRACTICE PAYMENT
Basis for Action: - UNKNOWN

Initial Action: - SETTLEMENT **Date of Action:** 10/15/2003
DCN: 5500000031351195

---------- **Unabridged Report(s) Follow** ----------

APR 23 2015

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

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http://www.npdb.hrsa.gov

PUDER, KAROLINE SUZANNE

THE DETROIT MEDICAL CENTER

MEDICAL MALPRACTICE PAYMENT REPORT

Date of Action: 08/21/2013

Initial Action

- SETTLEMENT

Basis for Initial Action

- FAILURE TO TREAT

A. REPORTING ENTITY

Entity Name:	THE DETROIT MEDICAL CENTER
Address:	4707 ST ANTOINE STE E510
City, State, Zip:	DETROIT, MI 48201
Country:	
Name or Office:	MARY MERITY
Title or Department:	CORPORATE DIRECTOR
Telephone:	(313) 993-0307
Entity Internal Report Reference:	
Type of Report:	INITIAL

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name:	PUDER, KAROLINE SUZANNE
Other Name(s) Used:	
Gender:	FEMALE
Date of Birth:	[redacted]
Organization Name:	NORTHWEST WOMEN'S CARE
Work Address:	6071 WEST OUTER DRIVE
City, State, ZIP:	DETROIT, MI 48235
Home Address:	[redacted]
City, State, ZIP:	SOUTHFIELD, MI 48034
Deceased:	NO
Social Security Numbers (SSN):	
Professional School(s) & Year(s) of Graduation:	MOUNT SINAI SCHOOL OF MEDICINE OF NEW YORK UNIVERSITY (1988)
Occupation/Field of Licensure (Code):	PHYSICIAN (MD)
State License Number, State of Licensure:	4301059142, MI
Drug Enforcement Administration (DEA) Numbers:	
Hospital Affiliation(s):	DETROIT MEDICAL CENTER HOSPITALS DETROIT,MI

C. INFORMATION REPORTED

Date of Report:	10/21/2013
Relationship of Entity to This Practitioner:	INSURANCE COMPANY - PRIMARY INSURER

PAYMENTS BY THIS PAYER FOR THIS PRACTITIONER

Amount of This Payment for This Practitioner:	$ 100,000.00
Date of This Payment:	08/21/2013
This Payment Represents:	A SINGLE FINAL PAYMENT
Total Amount Paid or to Be Paid by This Payer for This Practitioner:	$ 100,000.00
Payment Result of:	SETTLEMENT
Date of Judgment or Settlement, if Any:	08/02/2013

APR 23 2015

Adjudicative Body Case Number:	
Adjudicative Body Name:	
Court File Number:	09006715N
Description of Judgment or Settlement and Any Conditions, Including Terms of Payment:	SETTLEMENT REACHED AS A COMPROMISED WITH NO ADMISSION OF LIABILITY.

PAYMENTS BY THIS PAYER FOR OTHER PRACTITIONERS IN THIS CASE

Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case:	$ 200,000.00
Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case:	2

PAYMENTS BY OTHERS FOR THIS PRACTITIONER

Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?:	NO
Amount Paid or Expected to Be Paid by the State Fund:	
Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?:	NO
Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies:	

CLASSIFICATION OF ACT(S) OR OMISSION(S)

Patient's Age at Time of Initial Event:	0 DAYS
Patient's Gender:	UNKNOWN
Patient Type:	INPATIENT
Description of the Medical Condition With Which the Patient Presented for Treatment:	PATIENT PRESENTED PRENATALLY AND WAS DIAGNOSED WITH VASA PREVIA, VELAMENTOUS CORD INSERTION AND SHORTENED CERVIX.
Description of the Procedure Performed:	EMERGENCY CESAREAN SECTION WAS PERFORMED BY INSUREDS.
Nature of Allegation:	OBSTETRICS RELATED (050)
Specific Allegation:	FAILURE TO TREAT (113)
Date of Event Associated With Allegation or Incident:	11/18/2004
Outcome:	DEATH (09)
Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based:	ALLEGATIONS INVOLVE FAILURE TO ADMIT PATIENT TO HOSPITAL FOR INPATIENT MANAGEMENT OF ABOVE IDENTIFIED CONDITIONS RESULTING IN PREMATURE EMERGENCY CESAREAN SECTION AND DEATH OF FETUS.

D. SUBJECT STATEMENT

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

E. REPORT STATUS

Unless a box below is checked, the subject of this report identified in Section B has not contested this report.

☐ This report has been disputed by the subject identified in Section B.

☐ At the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

APR 23 2015

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PUDER, KAROLINE

THE DETROIT MEDICAL CENTER

MEDICAL MALPRACTICE PAYMENT REPORT

Date of Action: 10/15/2003

Initial Action

- SETTLEMENT

Basis for Initial Action

- UNKNOWN

A. REPORTING ENTITY

Entity Name:	THE DETROIT MEDICAL CENTER *
Address:	3663 WOODWARD AVENUE, SUITE 200
City, State, Zip:	DETROIT, MI 48201
Country:	
Name or Office:	MARY MERITY
Title or Department:	CORPORATE DIRECTOR
Telephone:	(313) 993-0307
Entity Internal Report Reference:	
Type of Report:	INITIAL

*The reporting entity has changed its name or address on file with the NPDB. The following is the entity's most recent contact information reported to the NPDB on 06/25/2013:

Entity Name:	THE DETROIT MEDICAL CENTER
Address:	4707 ST ANTOINE STE E510
City, State, Zip:	DETROIT, MI 48201
Country:	

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name:	PUDER, KAROLINE
Other Name(s) Used:	
Gender:	FEMALE
Date of Birth:	[redacted]
Organization Name:	HUTZEL HOSPITAL
Work Address:	4707 ST. ANTIONE BLVD.
City, State, ZIP:	DETROIT, MI 48201
Home Address:	
City, State, ZIP:	
Deceased:	NO
Social Security Numbers (SSN):	[redacted]
Professional School(s) & Year(s) of Graduation:	MOUNT SINAI SCHOOL OF MEDICINE (1988)
Occupation/Field of Licensure (Code):	PHYSICIAN (MD)
State License Number, State of Licensure:	059142, MI
Drug Enforcement Administration (DEA) Numbers:	
Hospital Affiliation(s):	

C. INFORMATION REPORTED

Date of Report:	10/21/2003
Act/Omission Code:	SURGERY: IMPROPER PERFORMANCE OF SURGERY (250)
Date of Act/Omission:	01/18/2001
Payment Date:	10/15/2003
Multiple or Single Payment:	SINGLE
Amount of This Payment:	$ 39,500.00
Total Amount of Judgment or Settlement:	$ 39,500.00

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Payment Result of:	SETTLEMENT
Number of Practitioners for Whom Payment is Made:	1
Relationship of Entity to the Practitioner:	SELF INSURED ORGANIZATION
Date of Judgment/Settlement:	09/22/2003
Adjudicative Case Number:	
Adjudicative Body Name:	
Court File Number:	
Reporter's Description of Act or Omission:	PLAINTIFF ALLEGES THAT ONE FALLOPIAN TUBE WAS MISSED DURING A POST-PARTUM TUBAL LIGATION ON THE 25 YEAR OLD PATIENT.
Reporter's Description of the Judgment or Settlement:	THE CASE WAS SETTLED FOR A TOTAL OF $39,500 FOR BUSINESS REASONS ONLY. THE PHYSICIAN DOES NOT ADMIT LIABILITY. THE PHYSICIAN HAS A NON-CONSENT INSURANCE POLICY.

D. SUBJECT STATEMENT

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

E. REPORT STATUS

Unless a box below is checked, the subject of this report identified in Section B has not contested this report.

☐ This report has been disputed by the subject identified in Section B.

☐ At the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

☐ At the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services and a decision was reached. The subject has requested that the Secretary reconsider the original decision.

☐ At the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

Date of Original Submission: 10/21/2003

Date of Most Recent Change: 10/21/2003

This report is maintained under the provisions of: Title IV

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of federal law. For additional information or clarification, contact the reporting entity identified in Section A.

END OF REPORT

APR 23 2015

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MIKE ZIMMER
DIRECTOR

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF April 20, 2015

NAME: Karoline S Puder **BIRTHDATE:** [redacted]

ADDRESS: [redacted]
Detroit MI 482010000

TYPE: Medical Doctor **ORIGINAL DATE:** 03/18/1992

LICENSE NUMBER: 4301059142 **STATUS:** Active **EXPIRATION DATE:** 01/31/2017

OBTAINED BY: Endorsement

EXAM DATE	EXAM TYPE	EXAM SCORE OR RESULT
03/01/1989	NBME	PASS

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

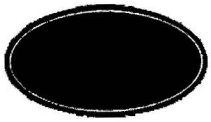
This license information was last updated on: 4/18/2015

RECEIVED DIRECT

LARA is an equal opportunity employer/program.
Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

HEALTH PROFESSIONS LICENSING DIVISION
611 W. OTTAWA ST. 1ST FL • P.O. BOX 30670 • LANSING, MICHIGAN 48909
http://www.michigan.gov/healthlicense • 517-335-0918

RECEIVED
APR 21 2015



Welcome to VeriDoc

Home [redacted]

Validation

This confirms that the attached licensure verification statement(s) for Karoline Puder, were sent to you from the VeriDoc website.

Thank you for using the VeriDoc system.

[redacted]

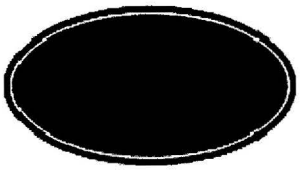
RECEIVED DIRECT

RECEIVED
APR 21 2015
By

Eddy, Elise md

From: ST, MEDICINE
Sent: Tuesday, April 21, 2015 7:51 AM
To: Eddy, Elise
Subject: FW: License Verification Statement - Puder, Karoline (MD)
Attachments: v242911AA.pdf

From: no-reply@veridoc.org [mailto:no-reply@veridoc.org]
Sent: Monday, April 20, 2015 9:20 PM
To: ST, MEDICINE
Subject: License Verification Statement - Puder, Karoline (MD)



Verification of Licensure Status

The attached verification report has been sent to you by the VeriDoc.org website. This email can be verified as coming from this site by clicking on the link below.

Validate Verifications

Physician: Puder, Karoline

Transaction ID: 242911

Confirmation Number: 18719223521555109198

Information from the attached verification can be refreshed for up to 6 months. To view an updated copy, click on link below.
Michigan Board of Medicine

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Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for: Pennsylvania State Board of Medicine As of Date:5/21/2015

PRACTITIONER INFORMATION

Name:	Karoline Suzanne Puder
DOB:	[redacted]
Medical School:	Mt Sinai School of Medicine of the City University of New York New York, New York, UNITED STATES
Year of Grad:	1988
Degree Type:	MD
NPI:	1790722288

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
MICHIGAN	4301059142	3/18/1992	1/31/2017	4/9/2015
NEW YORK	179533	8/16/1989	8/31/2016	5/20/2015

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PRACTITIONER PROFILE

Prepared for: Pennsylvania State Board of Medicine As of Date:5/21/2015

Practitioner Name: Karoline Suzanne Puder

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Obstetrics and Gynecology
Certificate: Obstetrics and Gynecology
Certification Type: General
Certification Status: Certified
Meeting MOC Requirements: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2014	12/31/2015		Recertification	4/30/2015
Expired	Time Limited	12/16/2013	12/31/2014		Recertification	4/30/2015
Expired	Time Limited	12/31/2012	12/31/2013		Recertification	4/30/2015
Expired	Time Limited	12/31/2011	12/31/2012		Recertification	4/30/2015
Expired	Time Limited	12/31/2010	12/31/2011		Recertification	4/30/2015
Expired	Time Limited	12/31/2009	12/31/2010		Recertification	4/30/2015
Expired	Time Limited	12/31/2008	12/31/2009		Recertification	4/30/2015
Expired	Time Limited	12/31/2007	12/31/2009		Recertification	4/30/2015
Expired	Time Limited	12/31/2006	12/31/2008		Recertification	4/30/2015
Expired	Time Limited	12/31/2005	04/30/2008		Recertification	4/30/2015
Expired	Time Limited	12/31/2004	04/30/2008		Recertification	4/30/2015
Expired	Time Limited	12/31/2003	12/31/2006		Recertification	4/30/2015
Expired	Time Limited	11/15/1996	12/31/2006		Initial	4/30/2015

Certifying Board: American Board of Obstetrics and Gynecology
Certificate: Maternal-Fetal Medicine
Certification Type: Subspecialty
Certification Status: Certified
Meeting MOC Requirements: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2014	12/31/2015		Recertification	4/30/2015
Expired	Time Limited	12/16/2013	12/31/2014		Recertification	4/30/2015
Expired	Time Limited	12/31/2012	12/31/2013		Recertification	4/30/2015
Expired	Time Limited	12/31/2011	12/31/2012		Recertification	4/30/2015
Expired	Time Limited	12/31/2010	12/31/2011		Recertification	4/30/2015

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PRACTITIONER PROFILE

Prepared for: Pennsylvania State Board of Medicine As of Date:5/21/2015

Practitioner Name: Karoline Suzanne Puder

Expired	Time Limited	12/31/2009	12/31/2010	Recertification	4/30/2015
Expired	Time Limited	12/31/2008	12/31/2009	Recertification	4/30/2015
Expired	Time Limited	12/31/2007	12/31/2009	Recertification	4/30/2015
Expired	Time Limited	12/31/2006	12/31/2008	Recertification	4/30/2015
Expired	Time Limited	12/31/2005	04/30/2008	Recertification	4/30/2015
Expired	Time Limited	12/31/2004	04/30/2008	Recertification	4/30/2015
Expired	Time Limited	12/31/2003	12/31/2006	Recertification	4/30/2015
Expired	Time Limited	04/08/1998	12/31/2006	Initial	4/30/2015

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5500000096448228
Process Date: 04/22/2015
Page: 1 of 1

PUDER, KAROLINE SUZANNE - SELF-QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: PUDER, KAROLINE SUZANNE
Date of Birth: [redacted] **Gender:** FEMALE
Work Address: 22880 COVENTRY WOODS LN, SOUTHFIELD, MI 48034-2108
Social Security Number: [redacted] **NPI:** 1790722288
License: PHYSICIAN (MD), 4301059142, MI, OBSTETRICS & GYNECOLOGY
Professional School(s): MOUNT SINAI SCHOOL OF MEDICINE OF NEW YORK UNIVERSITY (1988)

B. PAYMENT INFORMATION

Credit Card Information: [redacted]
NPDB Charge: $3.00* **NPDB Bill Reference Number:** N36829373
* Each charge will appear separately on your credit card statement.
Transaction Date: 04/22/2015 **Additional Paper Copies Requested:** 0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 04/22/2015

The following report types have been searched:

Medical Malpractice Payment Report(s):	**Yes, See Below**	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are enclosed for restricted/limited use as prescribed by statutes listed on the preceeding cover page.

THE DETROIT MEDICAL CENTER

MEDICAL MALPRACTICE PAYMENT
Basis for Action: - FAILURE TO TREAT

Initial Action: - SETTLEMENT **Date of Action:** 08/21/2013
DCN: 5500000085219573

THE DETROIT MEDICAL CENTER

MEDICAL MALPRACTICE PAYMENT
Basis for Action: - UNKNOWN

Initial Action: - SETTLEMENT **Date of Action:** 10/15/2003
DCN: 5500000031351195

---------- **Unabridged Report(s) Follow** ----------

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PUDER, KAROLINE SUZANNE

THE DETROIT MEDICAL CENTER

MEDICAL MALPRACTICE PAYMENT REPORT

Date of Action: 08/21/2013

Initial Action	Basis for Initial Action
- SETTLEMENT	- FAILURE TO TREAT

A. REPORTING ENTITY

Entity Name:	THE DETROIT MEDICAL CENTER
Address:	4707 ST ANTOINE STE E510
City, State, Zip:	DETROIT, MI 48201
Country:	
Name or Office:	MARY MERITY
Title or Department:	CORPORATE DIRECTOR
Telephone:	(313) 993-0307
Entity Internal Report Reference:	
Type of Report:	INITIAL

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name:	PUDER, KAROLINE SUZANNE
Other Name(s) Used:	
Gender:	FEMALE
Date of Birth:	[redacted]
Organization Name:	NORTHWEST WOMEN'S CARE
Work Address:	6071 WEST OUTER DRIVE
City, State, ZIP:	DETROIT, MI 48235
Home Address:	[redacted]
City, State, ZIP:	SOUTHFIELD, MI 48034
Deceased:	NO
Social Security Numbers (SSN):	
Professional School(s) & Year(s) of Graduation:	MOUNT SINAI SCHOOL OF MEDICINE OF NEW YORK UNIVERSITY (1988)
Occupation/Field of Licensure (Code):	PHYSICIAN (MD)
State License Number, State of Licensure:	4301059142, MI
Drug Enforcement Administration (DEA) Numbers:	
Hospital Affiliation(s):	DETROIT MEDICAL CENTER HOSPITALS DETROIT,MI

C. INFORMATION REPORTED

Date of Report:	10/21/2013
Relationship of Entity to This Practitioner:	INSURANCE COMPANY - PRIMARY INSURER

PAYMENTS BY THIS PAYER FOR THIS PRACTITIONER

Amount of This Payment for This Practitioner:	$ 100,000.00
Date of This Payment:	08/21/2013
This Payment Represents:	A SINGLE FINAL PAYMENT
Total Amount Paid or to Be Paid by This Payer for This Practitioner:	$ 100,000.00
Payment Result of:	SETTLEMENT
Date of Judgment or Settlement, if Any:	08/02/2013

MAY 1 2 2015

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Adjudicative Body Case Number:	
Adjudicative Body Name:	
Court File Number:	09006715N
Description of Judgment or Settlement and Any Conditions, Including Terms of Payment:	SETTLEMENT REACHED AS A COMPROMISED WITH NO ADMISSION OF LIABILITY.

PAYMENTS BY THIS PAYER FOR OTHER PRACTITIONERS IN THIS CASE

Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case:	$ 200,000.00
Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case:	2

PAYMENTS BY OTHERS FOR THIS PRACTITIONER

Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?:	NO
Amount Paid or Expected to Be Paid by the State Fund:	
Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?:	NO
Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies:	

CLASSIFICATION OF ACT(S) OR OMISSION(S)

Patient's Age at Time of Initial Event:	0 DAYS
Patient's Gender:	UNKNOWN
Patient Type:	INPATIENT
Description of the Medical Condition With Which the Patient Presented for Treatment:	PATIENT PRESENTED PRENATALLY AND WAS DIAGNOSED WITH VASA PREVIA, VELAMENTOUS CORD INSERTION AND SHORTENED CERVIX.
Description of the Procedure Performed:	EMERGENCY CESAREAN SECTION WAS PERFORMED BY INSUREDS.
Nature of Allegation:	OBSTETRICS RELATED (050)
Specific Allegation:	FAILURE TO TREAT (113)
Date of Event Associated With Allegation or Incident:	11/18/2004
Outcome:	DEATH (09)
Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based:	ALLEGATIONS INVOLVE FAILURE TO ADMIT PATIENT TO HOSPITAL FOR INPATIENT MANAGEMENT OF ABOVE IDENTIFIED CONDITIONS RESULTING IN PREMATURE EMERGENCY CESAREAN SECTION AND DEATH OF FETUS.

D. SUBJECT STATEMENT

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

E. REPORT STATUS

Unless a box below is checked, the subject of this report identified in Section B has not contested this report.

☐ This report has been disputed by the subject identified in Section B.

☐ At the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

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DCN: 5500000031351195
Process Date: 10/21/2003

PUDER, KAROLINE

PUDER, KAROLINE

THE DETROIT MEDICAL CENTER

MEDICAL MALPRACTICE PAYMENT REPORT

Date of Action: 10/15/2003

Initial Action	Basis for Initial Action
- SETTLEMENT	- UNKNOWN

A. REPORTING ENTITY

Entity Name: THE DETROIT MEDICAL CENTER *
Address: 3663 WOODWARD AVENUE, SUITE 200
City, State, Zip: DETROIT, MI 48201
Country:
Name or Office: MARY MERITY
Title or Department: CORPORATE DIRECTOR
Telephone: (313) 993-0307
Entity Internal Report Reference:
Type of Report: INITIAL

*The reporting entity has changed its name or address on file with the NPDB. The following is the entity's most recent contact information reported to the NPDB on 06/25/2013:

Entity Name: THE DETROIT MEDICAL CENTER
Address: 4707 ST ANTOINE
STE E510
City, State, Zip: DETROIT, MI 48201
Country:

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: PUDER, KAROLINE
Other Name(s) Used:
Gender: FEMALE
Date of Birth: [redacted]
Organization Name: HUTZEL HOSPITAL
Work Address: 4707 ST. ANTIONE BLVD.
City, State, ZIP: DETROIT, MI 48201
Home Address:
City, State, ZIP:
Deceased: NO
Social Security Numbers (SSN): [redacted]
Professional School(s) & Year(s) of Graduation: MOUNT SINAI SCHOOL OF MEDICINE (1988)
Occupation/Field of Licensure (Code): PHYSICIAN (MD)
State License Number, State of Licensure: 059142, MI
Drug Enforcement Administration (DEA) Numbers:
Hospital Affiliation(s):

C. INFORMATION REPORTED

Date of Report: 10/21/2003
Act/Omission Code: SURGERY: IMPROPER PERFORMANCE OF SURGERY (250)
Date of Act/Omission: 01/18/2001
Payment Date: 10/15/2003
Multiple or Single Payment: SINGLE
Amount of This Payment: $ 39,500.00
Total Amount of Judgment or Settlement: $ 39,500.00

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Payment Result of:	SETTLEMENT
Number of Practitioners for Whom Payment is Made:	1
Relationship of Entity to the Practitioner:	SELF INSURED ORGANIZATION
Date of Judgment/Settlement:	09/22/2003
Adjudicative Case Number:	
Adjudicative Body Name:	
Court File Number:	
Reporter's Description of Act or Omission:	PLAINTIFF ALLEGES THAT ONE FALLOPIAN TUBE WAS MISSED DURING A POST-PARTUM TUBAL LIGATION ON THE 25 YEAR OLD PATIENT.
Reporter's Description of the Judgment or Settlement:	THE CASE WAS SETTLED FOR A TOTAL OF $39,500 FOR BUSINESS REASONS ONLY. THE PHYSICIAN DOES NOT ADMIT LIABILITY. THE PHYSICIAN HAS A NON-CONSENT INSURANCE POLICY.

D. SUBJECT STATEMENT

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

E. REPORT STATUS

Unless a box below is checked, the subject of this report identified in Section B has not contested this report.

☐ This report has been disputed by the subject identified in Section B.

☐ At the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

☐ At the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services and a decision was reached. The subject has requested that the Secretary reconsider the original decision.

☐ At the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

Date of Original Submission:	10/21/2003
Date of Most Recent Change:	10/21/2003

This report is maintained under the provisions of: Title IV

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of federal law. For additional information or clarification, contact the reporting entity identified in Section A.

END OF REPORT

MAY 12 2015

Border

Recognizing and Reporting Child Abuse:
Mandated and Permissive Reporting in Pennsylvania

Meets ACT 31 of 2014 training requirements

3 continuing education hours

Presenter:

University of Pittsburgh School of Social Work, PA Child Welfare Resource Center
403 East Winding Hill Road, Mechanicsburg, PA 17055

Presented to:

PUDER, Karoline

pitt

on the date:

4/22/2015

maryroseSIG

MaryRose McCarthy, DirectorPA

tracysoskaSIG

Tracy Soska, Director of Continuing

Provider Number: CACE000004

CE Course Number: PCW000001

PRI E

MAY 1 2 2015

Magdalena Mozga • Marketing Coordinator
[redacted] • fax: 570.226.1147
[redacted]

MEMORANDUM

To: Commonwealth of Pennsylvania – State Board of Medicine

Re: Pennsylvania Temporary License for Camp Doctor

Date: April 27, 2015

Name of Applicant: Dr. Karoline Puder

Name of Camp: Camp Stone

Dates of service at Camp: 6/01/2015 - 8/31/2015

Enclosed, please find:

- ☑ Check payable to "Commonwealth of Pennsylvania"
- ☑ Completed Temporary License Application
- ☑ Camp Verification Form
- ☑ Back-Up Physician Form
- ☑ Current Curriculum Vitae
- ☑ Medical Malpractice Insurance Certificate

Thank you,

Maggie Mozga

Magdalena Mozga

MAY 1 2 2015

SINCE 1920
A·M·SKIER
INSURANCE

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@pa.gov
www.dos.state.pa.us/med

May 14, 2015

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

KAROLINE SUZANNE PUDER 9849
[redacted]
SOUTHFIELD MI 48034

EVALUATOR: ADRIENNE 1736

RE: DISCREPANCY NOTICE – Temporary License – Medical Board

Dear Applicant:

The Board has received your application for a Temporary license. The items listed below are needed to complete your application. A license cannot be issued until all items are received, approved and the application is complete. **You may not practice in the Commonwealth of Pennsylvania until a temporary license has been issued by the Board.**

- Application.
  - PLEASE PROVIDE PERSONAL STATEMENTS AND COPIES OF FULL COMPLAINTS

APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS WILL REQUIRE UPDATES OF CERTAIN DOCUMENTS.

You may check the status of your application online at www.mylicense.state.pa.us. Click on the link duplicate licenses/address changes/application status. First time users will be required to register and create a user ID and password. Your registration code to register is: 01447334

Sincerely,

Pennsylvania State Board of Medicine