[redacted]

TARGET SHEET

Board: Medicine

Licensee Full Name:
KAROLINE SUZANNE PUDER

License No:
TMD003877

[redacted]

3531898_LIC_1_03/29/2017

[redacted]

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.pa.gov

March 29, 2017

KAROLINE SUZANNE PUDER
MIDWEST CAMPERS INC
[redacted]
SUGAR GROVE PA 16350

TEMPORARY AUTHORITY TO PRACTICE

CLASSIFICATION:	Temporary MD License Camp Physician
TEMPORARY LICENSE #:	TMD003877
DATE OF APPROVAL:	06/01/2017
EXPIRATION DATE:	08/31/2017

Signature – Temporary Practice Holder

Commissioner
Bureau of Professional and Occupational Affairs

SEAL

TMD003877 6/1/17 to 8/31/17

(6/2015)

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

APPLICATION FEE: $45 fee. Check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of $20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

APPLICANT INFORMATION (Please Print or Type)

NAME:	Last Puder	First Karoline	Middle Suzanne
ADDRESS:	Street [redacted]		
City Southfield	State MI	ZIP 48034	
DATE OF BIRTH: [redacted]	**SOCIAL SECURITY NUMBER:** [redacted]		
EMAIL ADDRESS: [redacted]			
NAME OF MEDICAL SCHOOL ATTENDED:	Mt. Sinai School of Medicine		
DATE OF GRADUATION:	Month 6	Day 15	Year 1988
CURRENT STATE LICENSE BEING USED TO APPLY FOR A TEMPORARY LICENSE IN PA:	Michigan 059 142		

NAME AND ADDRESS OF PENNSYLVANIA HEALTH CARE FACILITY, CAMP OR ORGANIZATION

NAME OF ORGANIZATION:	MIDWEST CAMPERS, INC.		
ADDRESS:	Street 2145 DEER RUN ROAD		
City: SUGAR GROVE	State PA	ZIP 16350	

NAME AND ADDRESS OF BACK-UP PHYSICIAN, SUPERVISOR OR AGENCY HEAD

NAME:	Last MATLAGA	First ROMAN	Middle
ADDRESS:	Street [redacted]		
City: HAWLEY	State PA	ZIP 18428	

MAR 13 2017

LEGAL QUESTIONS

You must answer the following questions. If you answer "YES" to #2 through #12, provide complete details on a separate sheet as well as certified copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? **If you answered yes, provide the profession and state or jurisdiction.** **LIST:** Medicine - NY + MI, temp PA	✓	
2	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		✓
3	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		✓
4	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		✓
5	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		✓
6	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		✓
7	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		✓
8	Have you had your DEA registration denied, revoked or restricted?		✓
9	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		✓
10	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		✓
11	Have you engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]	
12	Have you been the subject of a civil malpractice lawsuit? **If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you.** ****If you previously reported the complaint to the Board provide the docket number** MI - 09-006715 - NJ	✓	

SIGNED STATEMENT

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

[redacted]

Signature of Applicant

3/5/17

Date

Karoline S. Rider M.D

Printed Name of Applicant

MAR 13 2017

Personal Statement Regarding Prior Medical Malpractice

Karoline Suzanne Puder, MD

I have been in academic practice in Detroit, Michigan since completing my fellowship in Maternal-Fetal Medicine, in 1994. In that time period, two cases have been settled in which I was a named party. In both cases, the hospital/medical center was a co-defendant and dictated decisions regarding settlement.

The first case settled in 2003 and was related to a tubal ligation failure. The postpartum tubal ligation was performed in the usual manner and segments of the tubes were sent to pathology for exam. Review of the results showed that one tube may not have been ligated. The patient was contacted and informed. She was told to use alternative contraception and to come for follow up. She did not return, but did come to the emergency department stating that she had been told of this concern. She was instructed to follow-up in the gynecology office for further management, which she did not do. She then became pregnant, chose to have a termination, and ultimately had a laparoscopic tubal ligation. The case was settled for business purposes and I have a non-consent policy.

The second case in which I was named, I served as a consultant and not the primary caregiver. That case settled in 2013 and is referenced in the DataBank report. This matter is related to a diagnosis of vasa previa made in the midtrimester. The patient was counseled by me and her care was otherwise performed by her primary obstetrician. She had a hospital admission for preterm contractions. She was discharged from the hospital by her OB and with follow up with her OB. She agreed to discharge and outpatient follow up. She reported that she lived near the hospital, had transportation, had another adult in the house, and wished to be at home. She did not follow up with me, as recommended and presented with bleeding. Her child subsequently has developmental delay. The DataBank report is inaccurate, because the child was still alive at the time of the litigation (and I have no knowledge of a change in status). I was included as a defendant because I did not force her to stay in the hospital. I was not the discharging physician. Standard of care did not dictate inpatient management. This case was settled for business purposes due to hospital corporate concerns about excessive award at trial due to the child's developmental delay and the prevailing malpractice environment in the area. I had a non-consent policy for this, as well.

Regular Mailing Address
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P.O. BOX 2649
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717-783-1400/717-787-2381
Email: st-medicine@pa.gov

Courier Delivery Address
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.	Provide an official notification of information (Self Query) from the National Practitioner Data Bank Data Bank. Please refer to the NPDB website for additional information. When you receive the "Response to your Self Query," forward the entire report directly to the Board Office. You should make a copy for your records.
8.	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.

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.
PLEASE NOTE: If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.

HOSPITAL, HEALTH CARE FACILITY, EMPLOYER OR CAMP VERIFICATION FORM

PENNSYLVANIA HEALTH CARE FACILITY, CAMP OR ORGANIZATION

NAME OF ORGANIZATION:	Midwest Campers, Inc.
ADDRESS:	Street: 2145 Deer Run Road

City:	State	ZIP
Sugar Grove	PA	16350

NAME OF APPLICANT:	Last	First	Middle
	Puder	Karoline	Suzanne

DATES OF SERVICE FOR THE APPLICANT:	**From**: Month/Day/Year	**To**: Month/Day/Year
	6/1/2017	8/31/2017

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:	Registrar / Office Mgr.		
SIGNATURE:	Randi Mashmoor		
DATE:	Month: January	Day: 26	Year: 2017

MAR 13 2017

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: 06/01/2017	To: Month/Day/Year: 08/31/2017	

PENNSYLVANIA HEALTH CARE FACILITY, CAMP OR ORGANIZATION

NAME OF ORGANIZATION:	Midwest Campers, Inc.		
ADDRESS:	Street: 2145 Deer Run Road		
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 & pain medication. Refer to specialist if a medical problem is beyond his/her expertise or ability.

SIGNATURE OF COLLABORATING/ BACK-UP PHYSICIAN:	[redacted]		
DATE:	Month: January	Day: 26	Year: 2017

MAR 13 2017

Signature: [redacted]

Date: March 5, 2017

KAROLINE SUZANNE PUDER, M.D.

ADDRESS:

Office:

Department of Obstetrics and Gynecology
Hutzel Women's Hospital/Wayne State University
3990 John R
Detroit, MI 48201
[redacted]

Home:

[redacted]
Southfield, MI 48034
[redacted]

PERSONAL DATA:

Birth Date: [redacted]

EDUCATION:

Undergraduate:

City College of New York. Sophie Davis School of Biomedical Education.
New York, New York
Seven year B.S./M.D. program.
Bachelor of Science
September 1981-June 1986

Medical:

Mount Sinai School of Medicine
New York, New York
Doctor of Medicine
July 1986-June 1988

Residency:

Mount Sinai Medical Center, Department of Obstetrics and Gynecology
New York, New York
July 1988-June 1992

Fellowship:

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

ACADEMIC APPOINTMENTS:

Clinical Instructor in Obstetrics and Gynecology, Wayne State University.
Detroit, Michigan
July 1992 - June 1994

Assistant Professor, Obstetrics and Gynecology, Wayne State University.
Detroit, Michigan
July 1994 – July 2009

Associate Professor, Obstetrics and Gynecology, Wayne State University.
Detroit, Michigan
August 2009 – present

Residency Site Coordinator, Sinai-Grace Hospital, Wayne State University.
Detroit, Michigan
July 2000 – 2014

PROFESSIONAL APPOINTMENTS:

Vice Chief, Department of Obstetrics and Gynecology, Sinai-Grace Hospital.
Detroit, Michigan
July, 2003 to December, 2010

Chief of Obstetrics
Hutzel Women's Hospital/Harper University Hospital
Detroit MI
February 2014 - present

MEDICAL STAFF APPOINTMENTS:

Hutzel Hospital	1992 - present
Detroit Receiving Hospital	1992 - present
Harper Hospital	1992 - present
Sinai-Grace Hospital	1994 - present
Huron Valley Hospital	1997 - present

PROFESSIONAL SOCIETY AFFILIATIONS:

American College of Obstetricians and Gynecologist - Fellow

Society for Maternal Fetal Medicine - Regular Member
Michigan State Medical Society - Regular Member
American Institute of Ultrasound in Medicine - Regular Member

LICENSURE:

State of New York Medical License - #179533
State of Michigan Medical License - #059142

BOARD CERTIFICATION:

American Board of Obstetrics and Gynecology, Maternal Fetal Medicine, 1998. Recertification 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016. #929468M valid through December 31, 2017.

American Board of Obstetrics and Gynecology, 1996. Recertification 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016. #929468M valid through December 31, 2017.

National Board of Medical Examiners Certificate # 33603564

Step 1:	06/10/1986
Step 2:	09/29/1987
Step 3:	03/01/1989

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY): 3/9/2017

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 Midwest Campers, Inc. 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	$
A	Professional Liability			8502CY4190022	11/1/2016	11/1/2017	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: 6/1/2017 - 8/31/2017.

CERTIFICATE HOLDER

Dr. Karoline Suzanne Puder
Midwest Campers, Inc.
2145 Deer Run Road
Sugar Grove, PA 16350

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

MAR 13 2017

NATIONAL PRACTITIONER DATA BANK

NPDB

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

https://www.npdb.hrsa.gov

5500000121741203
Process Date: 03/05/2017
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
Delivery Address: [redacted] SOUTHFIELD, MI 48034-2108
Social Security Numbe [redacted] **NPI:** 1790722288
License: PHYSICIAN (MD), 059142, MI, OBSTETRICS & GYNECOLOGY
PHYSICIAN (MD), 179533, NY, OBSTETRICS & GYNECOLOGY
Professional School(s): MOUNT SINAI SCHOOL OF MEDICINE OF NEW YORK UNIVERSITY (1988)

B. PAYMENT INFORMATION

Credit Card Information: [redacted]
NPDB Charge: $4.00* **NPDB Bill Reference Number:** N51865531
* Each charge will appear separately on your credit card statement.
Transaction Date: 03/05/2017 **Additional Paper Copies Requested:** 0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 03/05/2017

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
DCN: 5500000085219573
Date of Action: 08/21/2013

THE DETROIT MEDICAL CENTER
MEDICAL MALPRACTICE PAYMENT
Basis for Action: - UNKNOWN
Initial Action: - SETTLEMENT
DCN: 5500000031351195
Date of Action: 10/15/2003

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

MAR 13 2017

NATIONAL PRACTITIONER DATA BANK
NPDB
P.O. Box 10832
Chantilly, VA 20153-0832

https://www.npdb.hrsa.gov

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

*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 04/27/2015:

Entity Name: THE DETROIT MEDICAL CENTER
Address: 4707 SAINT ANTOINE ST STE E510
City, State, Zip: DETROIT, MI 48201-1427
Country:

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

MAR 13 2017

NATIONAL PRACTITIONER DATA BANK
NPDB
P.O. Box 10832
Chantilly, VA 20153-0832

https://www.npdb.hrsa.gov

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
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.

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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: 10/21/2013
Date of Most Recent Change: 10/21/2013

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

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DISCLOSURE HISTORY

Report Number: 5500000085219573

F. DISCLOSURE HISTORY

Recipient(s) of the Current Version of this Report

A copy of this report has been disclosed to the following entity(entities) for limited/restricted use under the statutory provisions specified in this report. Additionally, all active entities who received an earlier version of this report within the three year period prior to the date this report was submitted or changed were mailed a copy of the current version.

Date Released	Entity Name
04/16/2014	THE DETROIT MEDICAL CENTER 4707 SAINT ANTOINE ST STE E510 DETROIT, MI 48201 (313) 745-1250
01/07/2015	BLUE CARE NETWORK 20500 CIVIC CENTER DR MAIL CODE C312 SOUTHFIELD, MI 48076 (248) 226-5299
03/18/2015	WAYNE STATE UNIVERSITY PHYSICIAN GROUP 1560 E MAPLE RD STE 400 TROY, MI 48083 (248) 581-5969
04/22/2015	SELF-QUERIER
03/06/2016	SELF-QUERIER
04/01/2016	AETNA LIFE INSURANCE COMPANY AND ITS AFFILIATES 151 FARMINGTON AVENUE HARTFORD, CT 06156 (860) 257-3946

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DCN: 5500000085219573
Process Date: 10/21/2013

PUDER, KAROLINE SUZANNE

Date Released	Entity Name
04/18/2016	THE DETROIT MEDICAL CENTER 4707 SAINT ANTOINE ST STE E510 DETROIT, MI 48201 (313) 745-1250
06/09/2016	SELF-QUERIER
03/05/2017	SELF-QUERIER

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