[redacted]

TARGET SHEET

Board: Medicine

Licensee Full Name:
KAROLINE SUZANNE PUDER

License No:
TMD003498

3225256_LIC_1_05/21/2014

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.state.pa.us

May 21, 2014

KAROLINE SUZANNE PUDER
CAMP STONE
[redacted]
SUGAR GROVE PA 16350

TEMPORARY AUTHORITY TO PRACTICE

CLASSIFICATION:	Temporary MD License Camp Physician
TEMPORARY LICENSE #:	TMD003498
DATE OF APPROVAL:	06/01/2014
EXPIRATION DATE:	08/31/2014

Signature – Temporary Practice Holder

Travis N. Gery

Commissioner
Bureau of Professional and Occupational Affairs

SEAL

M

6/1-8/31

(01/2012)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
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

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: Month [redacted]	**SOCIAL SECURITY NUMBER:** [redacted]		
EMAIL ADDRESS: [redacted]			
NAME OF MEDICAL SCHOOL ATTENDED:	Mt. Sinai Schod of Medicine		
DATE OF GRADUATION:	Month June	Day	Year 1988
CURRENT STATE LICENSE BEING USED TO APPLY FOR A TEMPORARY LICENSE IN PA:	Michigan.		

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

NAME OF ORGANIZATION:	Camp Stone.		
ADDRESS:	Street [redacted]		
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	

1

APR 30 2014

3474 AMS

LEGAL QUESTIONS

YOU MUST ANSWER THE FOLLOWING QUESTIONS.

If you answer "YES" to #2 through #7, provide complete details on a separate sheet of paper as well as certified copies of relevant documents. **Sign and date below.**

		Yes	No
1.	Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in any jurisdiction? **If yes, list the jurisdiction(s) here:** MI + NY	✓	
2.	Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		✓
3.	Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		✓
4.	Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		✓
5.	Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		✓
6.	Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
7.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Pennsylvania Department of State Professional Health Monitoring Program.**		[redacted]

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine 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). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

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. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

[redacted] 4/20/14

Signature of Applicant Date

APR 30 2014

APR 2 8 2014

(01/2012)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
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 in their official Board envelope.
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.

IMPORTANT INFORMATION

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

APR 3 0 2014

(01/2012)

CAMP VERIFICATION FORM

PENNSYLVANIA CAMP

NAME OF CAMP:	Camp Stone		
ADDRESS:	Street [redacted]		
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 6/1/2014	To: Month/Day/Year 8/31/2014	

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:	NANCY NEWMARK			
TITLE:	ADMINISTRATOR			
SIGNATURE:	[redacted]			
DATE:	Month: 01	Day: 28	Year: 2014	

APR 30 2014

(01/2012)

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: 6/1/2014	To: Month/Day/Year: 8/31/2014	

PENNSYLVANIA HEALTH CARE FACILITY, CAMP OR ORGANIZATION

NAME OF ORGANIZATION:	Camp Stone		
ADDRESS:	Street: [redacted]		
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: January	Day: 31	Year: 2014

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

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY): 4/26/2014

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

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: ACE-Indemnity Insurance Company of North America	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER F:	

INSURED

Camp Stone
[redacted]
Sugar Grove, PA 16350

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	SUB R	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	☐ CLAIMS MADE ☐ OCCUR	☐	☐				MED EXP (Any one person)	$
							PERSONAL AND ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT	$
	☐ ANY AUTO						BODILY INURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS	☐	☐				BODILY INURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE	$
							Deductible:	$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE	☐	☐				AGGREGATE	$
	☐ DED ☐ RETENTION $							
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A	☐			E.L. EACH ACCIDENT	$
							E.L. DISEASE - EACH EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
	Professional Liability	☐	☐	D35776850	11/1/2013	11/1/2014	1,000,000 per occurance; 2,000,000 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: 6/1/2014 - 8/31/2014.

CERTIFICATE HOLDER

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

APR 30 2014

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 REPRESENTATIVE

HENRY M. SKIER
President

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES

STEVE ARWOOD
DIRECTOR

VERIFICATION OF LICENSURE

MICHIGAN BOARD OF MEDICINE

VERIFICATION OF LICENSURE AS OF May 14, 2014

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: 5/13/2014

HEALTH PROFESSIONS DIVISION
611 W. OTTAWA ST. 1ST FL • P.O. BOX 30670 • LANSING, MICHIGAN 48909

Welcome to VeriDoc

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.

Eddy, Elise md

From: ST, MEDICINE
Sent: Thursday, May 15, 2014 7:30 AM
To: Eddy, Elise
Subject: FW: License Verification Statement - Puder, Karoline (MD)
Attachments: v197058AA.pdf

State Board of Medicine

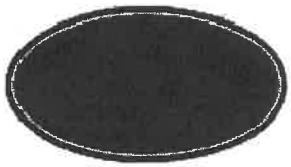
PA Department of State | Bureau of Professional and Occupational Affairs

PO Box 2649 | Harrisburg PA 17105

Phone: 717.783.1400 | Fax: 717.787.7769

www.dos.state.pa.us/med | st-medicine@pa.gov

From: support@veridoc.org [mailto:support@veridoc.org]
Sent: Wednesday, May 14, 2014 6:56 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: 197058

Confirmation Number: 30102167115171571024

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

RECEIVED DIRECT

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 29, 2014

Name of Applicant: Karoline Suzanne Puder

Name of Camp: Camp Stone

Dates of service at Camp: 6/1/2014 - 8/31/2014

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,

Magdalena Mozga

Magdalena Mozga

APR 30 2014

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 8, 2014

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

KAROLINE SUZANNE RUDER [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.**

- Letter of good standing from the following State Board(s) **must be received DIRECTLY from the licensing board in an official, sealed envelope**.
  - MI

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: x8V7iXmG

Sincerely,

Pennsylvania State Board of Medicine

The Federation of State Medical Boards
of the United States, Inc.
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
FAX (817) 868-4099

BOARD ACTION CLEARANCE REPORT

May 21, 2014

Pennsylvania State Board of Medicine
Attn: Micheal Coates
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: May 21, 2014
Your Reference Number: AB
FSMB Batch Number: BQ2443924

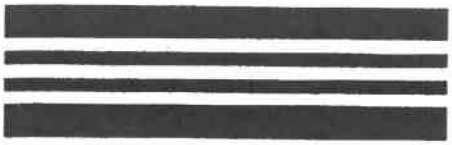
The following is a report of the search results from the Board Action Data Bank as of May 21, 2014 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 21, 2014

Item	Name	DOB	School	Yr/Grad	Request ID
1	PUDER, KAROLINE SUZANNE	[redacted]		1988	27337013

LICENSE HISTORY
State Board
MICHIGAN
NEW YORK

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



TARGET SHEET

Board: Medicine

Licensee Full Name:
KAROLINE SUZANNE PUDER

License No:
TMD003118

3000544_LIC_1_04/12/2012

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.state.pa.us

April 12, 2012

KAROLINE SUZANNE PUDER
CAMP STONE
[redacted]
SUGAR GROVE PA 16350

TEMPORARY AUTHORITY TO PRACTICE

CLASSIFICATION:	Temporary MD License Camp Physician
TEMPORARY LICENSE #:	TMD003118
DATE OF APPROVAL:	07/08/2012
EXPIRATION DATE:	07/15/2012

Signature – Temporary Practice Holder

Katie True

Commissioner
Bureau of Professional and Occupational Affairs

SEAL

MAR 2012

49-103 (03/08)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR TEMPORARY LICENSE TMD003118

Application Fee: **$45.00** not refundable. Make check payable to the "Commonwealth of Pennsylvania." **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.

(PRINT OR TYPE) 287454

Applicant Information

Name Puder (LAST) Karolina (FIRST) Suzanne (MIDDLE)

Address [redacted] (STREET)

Southfield (CITY) MI (STATE) 48034 (ZIP CODE)

Date of Birth [redacted] Social Security Number [redacted]

Name of Medical School (s) Attended Mt. Sinai School of Medicine

Date of Graduation 1988

Identify which state license you are using to apply for the temporary license Michigan

Name and address of Pennsylvania Health Care Facility, Camp, or Organization of Employment

Name CAMP STONE

Address [redacted] (STREET)

SUGAR GROVE (CITY) PA (STATE) 16350 (ZIP CODE)

Name and address of Attending Physician, Supervisor, or Agency Head

Name DR. ROMAN MATLAGA

Address [redacted] (STREET)

HONESDALE (CITY) PA (STATE) 18431 (ZIP CODE)

MAR 19 2012

Answer the following questions. If "YES" is answered to #2 through #7, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	YES	NO
1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in any jurisdiction? **If yes, list the jurisdiction(s) here:** Michigan, NY	✓	
2) Have you ever withdrawn an application for a license, certification, or registration, had an application denied or refused, or agreed not to reapply in another state, territory or country?		✓
3) Has any disciplinary action been taken against your license, certification, or registration in another state, territory or country?		✓
4) Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?		✓
5) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		✓
6) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
7) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)**	[redacted]	

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine 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). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

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. Section 4904 relating to unsworn fa[redacted] result in the suspension or revocation of my license or certificate.

[redacted] 3/11/12

Signature of Applicant Date

MAR 19 2012

49-103 (03/08)

HOSPITAL, HEALTH CARE FACILITY, EMPLOYER OR CAMP VERIFICATION FORM

Name and Address of Pennsylvania Health Care Facility, Camp, or organization of employment:

Name Camp Stone

Address [redacted]
Street

Sugar Grove, PA 16350
City State Zip Code

Name of Temporary License Applicant Karoline Puder

Dates of service for the Applicant 7/8/12 - 7/15/12

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.

Signature [redacted]

Title Administrator

Date 2/15/12

OK

49-103 (03/08)

COLLABORATING/BACK UP DOCTOR FORM

Collaborating/Back-Up Doctor's Name Roman Matlaga, DO

License Number of Collaborating/Back-Up Doctor MD 05-008779-L

Name of Temporary License Applicant Karoline Puder

Dates You Will Serve as the Collaborating/Back-Up Doctor 7/8/2012 - 7/15/2012

Name and Address of Pennsylvania Health Care Facility, Camp, or organization of employment:

Name Young Israel Camp Stone

Address [redacted]
Street

Sugar Grove	PA	16350
City	State	Zip Code

I Agree to Serve as the Collaborating/Back-Up Doctor for the Above Named Applicant in the Performance of the Following Listed Duties/Procedures:

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

Signature of Collaborating/Back-Up Doctor [redacted]

Date 3/5/12

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY): 3/2/2012

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 [redacted] Sugar Grove, PA 16350	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A: ACE-Indemnity Insurance Company of North America 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 INJURY (Per person) $ BODILY INJURY (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? Y/N [N] (Mandatory in NH) 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	☐	☐	D35776850	11/1/2011	11/1/2012	$1,000,000 per occurrence $2,000,000 per 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: 07/08/2012 to 07/15/2012.

MAR 19 2012

CERTIFICATE HOLDER

Dr. Karoline Puder
Camp Stone
[redacted]
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 REPRESENTATIVE
HENRY M. SKIER
President

JENNIFER M. GRANHOLM
Governor

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
Director

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 03/11/2012

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

ADDRESS: [redacted]
Detroit MI 482350000

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

LICENSE NUMBER: 4301059142 **STATUS:** Active **EXPIRATION DATE:** 01/31/2014

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: 03/11/2012

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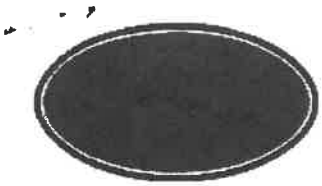
RECEIVED
MAR 12 2012
By

BUREAU OF HEALTH PROFESSIONS
611 W. OTTAWA • P.O. BOX 30670 • LANSING, MICHIGAN 48909-8170
www.michigan.gov • (517) 335-0918



Home

Contact Us | FAQs | State Boards

Validation

This confirms that the MI licensure verification statement for Karoline Puder, was sent to you from the VeriDoc website.

Thank you for using the VeriDoc system.

v2

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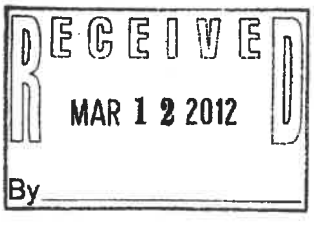

Signature: _____

Date: March 4, 2012

KAROLINE SUZANNE PUDER, M.D.

ADDRESS:

Office:

Department of Obstetrics and Gynecology
Sinai-Grace Hospital/Wayne State University
6071 West Outer Drive
Detroit, MI 48235
[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 – present

PROFESSIONAL APPOINTMENTS:

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

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. #929468M valid through December 31, 2011.

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

National Board of Medical Examiners Certificate # 33603564

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

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

April 12, 2012

Attn: Tammy Dougherty
Pennsylvania State Board of Medicine
Tammy Dougherty
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: April 12, 2012
Your Reference Number: ahollinger
FSMB Batch Number: BQ2059119

The following is a report of the search results from the Board Action Data Bank as of April 12, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 12, 2012

Item	Name	DOB	School	Yr/Grad	Request ID
1	FLEISCHMANN, JONATHAN	[redacted]		1978	25149499
		LICENSE HISTORY State Board NEW YORK OHIO			
2	PUDER, KAROLINE SUZANNE	[redacted]		1988	25149500
		LICENSE HISTORY State Board MICHIGAN NEW YORK			
3	ROSENBERG, ERIC ADAM	[redacted]		1997	25149501
		LICENSE HISTORY State Board NEW YORK			

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

49-103 (03/08)

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.**

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 insurance company, which verifies malpractice insurance coverage at this facility during 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 in an official Board envelope.

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.

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 your license.**
- **Failure to provide sufficient information and supporting documents may result in a processing delay or the return of your application.**

Magdalena Mozga • Workshops Coordinator
570.226.4571 • fax: 570.226.1147
MagdalenaM@amskier.com

MEMORANDUM

To: Commonwealth of Pennsylvania – State Board of Medicine

Re: Pennsylvania Temporary License for Camp Doctor

Date: 3/16/2012

Name of Applicant: Karoline Puder

Name of Camp: Camp Stone

Dates of service at Camp: 7/8/2012 – 7/15/2012

Enclosed, please find:

- ☑ Completed Temporary License Application
- ☑ Check in the amount of $ 45.00
- ☑ Letter from Back-Up Physician
- ☑ Letter from Camp Director
- ☑ Current Curriculum Vitae
- ☑ Medical Malpractice Insurance Certificate

Thank you,

Magdalena Mozga

MAR 19 2012

(02/2017)

PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE

VERIFICATION OF MEDICAL EDUCATION
(For Graduates of Osteopathic Medical Schools)

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
	Kurz	Daniel	William

NAME OF MEDICAL SCHOOL:	Rowan University School of Osteopathic Medicine
LOCATION:	One Medical Center Drive, Stratford, NJ 08084

Submit the verification of medical education form to your medical school and request the school return the completed form directly to the board in an official school envelope.

SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL

NAME OF MEDICAL SCHOOL:	Rowan University School of Osteopathic Medicine			
NAME OF MEDICAL STUDENT:	Last: KURZ	First: DANIEL		Middle: W
DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:		Month: 08	Day: 12	Year: 13
DATE OF GRADUATION:		Month: 05	Day: 30	Year: 17

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

SIGNATURE OF DEAN/REGISTRAR:	Regina Williams			
DATE:	Month: 04	Day: 05	Year: 17	

(Seal of School)

This form may be completed **ONLY three months prior to graduation**. Upon completion, school must return this completed form directly to the Pennsylvania State Board of Osteopathic Medicine in an official school envelope.

****** IF GRADUATION DOES NOT TAKE PLACE, NOTIFY THE BOARD IMMEDIATELY******

DO NOT RETURN THIS FORM TO THE APPLICANT

Regular Mailing Address
STATE BOARD OF OSTEOPATHIC MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-4858

Courier Delivery Address
STATE BOARD OF OSTEOPATHIC MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

RECEIVED DIRECT

[redacted]

TARGET SHEET

Board: Medicine

Date Created:
04/29/2010

Licensee Full Name:
KAROLINE SUZANNE PUDER

License No:
TMD002786

[redacted]

APPL 2788410

[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.state.pa.us

April 29, 2010

KAROLINE SUZANNE PUDER
CAMP STONE
[redacted]
SUGAR GROVE PA 16350

TEMPORARY AUTHORITY TO PRACTICE

CLASSIFICATION:	Temporary MD License Camp Physician
TEMPORARY LICENSE #:	TMD002786
DATE OF APPROVAL:	06/27/2010
EXPIRATION DATE:	07/04/2010

Signature – Temporary Practice Holder

Basil L. Merenda
Commissioner
Bureau of Professional and Occupational Affairs

SEAL

49-103 (03/08)

APR 16 2010

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR TEMPORARY LICENSE

TMD002786

Application Fee: **$45.00** not refundable. Make check payable to the "Commonwealth of Pennsylvania." **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.

(PRINT OR TYPE)

230245

Applicant Information

Name Puder (LAST) Kardinz (FIRST) Suzanne (MIDDLE)

Address [redacted] (STREET)

Southfield (CITY) MI (STATE) 48034 (ZIP CODE)

Date of Birth [redacted] Social Security Number [redacted]

Name of Medical School (s) Attended Mt. Sinai School of Medicine

Date of Graduation 1988

Identify which state license you are using to apply for the temporary license Michigan.

Name and address of Pennsylvania Health Care Facility, Camp, or Organization of Employment

Name Camp Stone

Address [redacted] (STREET)

Sugar Grove (CITY) PA (STATE) 16350 (ZIP CODE)

Name and address of Attending Physician, Supervisor, or Agency Head

Name Dr Roman Mallaga

Address [redacted] (STREET)

Honesdale (CITY) PA (STATE) 18431 (ZIP CODE)

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APR 22 2010

49-103 (03/08)

Answer the following questions. If "YES" is answered to #2 through #7, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	YES	NO
1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in any jurisdiction? **If yes, list the jurisdiction(s) here:** Michigan, NJ	✓	
2) Have you ever withdrawn an application for a license, certification, or registration, had an application denied or refused, or agreed not to reapply in another state, territory or country?		✓
3) Has any disciplinary action been taken against your license, certification, or registration in another state, territory or country?		✓
4) Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?		✓
5) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		✓
6) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
7) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)**	[redacted]	

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine 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). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

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. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

[redacted] 4/12/10

Signature of Applicant Date

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BY

49-103 (03/08)

HOSPITAL, HEALTH CARE FACILITY, EMPLOYER OR CAMP VERIFICATION FORM

[redacted] of Pennsylvania Health Care Facility, Camp, or organization of employment:

Name Camp Stone

Address [redacted]
Street

Sugar Grove | PA | 16350
City | State | Zip Code

Name of Temporary License Applicant Karoline Puder

Dates of service for the Applicant JUNE 27 - July 4, 2010

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.

Signature [redacted]

Title Administrator

Date 3/24/2010

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By

21C

49-103 (03/08)

MAR 3 0 2010

COLLABORATING/BACK UP DOCTOR FORM

Collaborating/Back-Up Doctor's Name Roman Matlaga, DO

License Number of Collaborating/Back-Up Doctor MD 05-008779-L

Name of Temporary License Applicant Dr. Karoline Puder

Dates You Will Serve as the Collaborating/Back-Up Doctor 6-27-10 to 7-4-10

Name and Address of Pennsylvania Health Care Facility, Camp, or organization of employment:

Name Young Israel Camp Store

Address [redacted]
Street

Sugar Grove (City) PA. (State) 16350 (Zip Code)

I Agree to Serve as the Collaborating/Back-Up Doctor for the Above Named Applicant in the Performance of the Following Listed Duties/Procedures:

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

Signature of Collaborating/Back-Up Doctor [redacted]

Date 3/26/2010

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APR 22 2010
By

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY) 4/19/2010

PRODUCER

A. M. Skier Agency
209 Main Avenue
Hawley, PA 18428

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED NY THE POLICIES BELOW.

INSURED

Young Israel Camp Stone
[redacted]
Sugar Grove, PA 16350

COMPANIES AFFORDING COVERAGE

COMPANY A: ACE American Insurance Company

COMPANY B:

COMPANY C:

COMPANY D:

COVERAGES

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.

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE	LIMITS	
	GENERAL LIABILITY				GENERAL AGGREGATE	$
	☐ COMMERCIAL GENERAL LIABILITY				PRODUCTS - COMP/OP AGG	$
	☐ CLAIMS MADE ☐ OCCUR				PERSONAL AND ADV INJURY	$
	OWNERS AND CONTRACTORS PROT				EACH OCCURRENCE	$
					FIRE DAMAGE (Any one fire)	$
					MED EXP (Any one person)	$
	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT	$
	☐ ANY AUTO				BODILY INURY (Per person)	$
	☐ ALL OWNED AUTOS					
	☐ SCHEDULED AUTOS				BODILY INURY (Per accident)	$
	☐ HIRED AUTOS					
	☐ NON-OWNED AUTOS				PROPERTY DAMAGE	$
	☐ Comp Ded					
	☐ Coll Ded					
	GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
	☐ ANY AUTO				OTHER THAN AUTO ONLY:	
					EACH ACCIDENT	$
					AGGREGATE	$
	EXCESS LIABILITY				EACH OCCURRENCE	$
	☐ UMBRELLA FORM				AGGREGATE	$
	☐ OTHER THAN UMBRELLA FORM					
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATUTORY LIMITS	$
	THE PROPRIETORY/ PARTNERS/EXECUTIVE OFFICERS ARE: ☐ INCL. ☐ EXCL				EL EACH ACCIDENT	$
					EL DISEASE - POLICY LIMIT	$
					EL DISEASE - EA EMPLOYEE	$
A	OTHER Professional Liability	D35776850	11/1/2009	11/1/2010	1,000,000 per occurance aggregate	2,000,000

SINCE 1920
A·M·SKIER
INSURANCE

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHILCES/SPECIAL ITEMS

For the dates of service while at camp: 6/27/10 to 7/4/10.

CERTIFICATE HOLDER

Dr. Karoline Puder
Young Israel Camp Stone
R. D. 2, Deer Run Road
Sugar Grove, PA 16350

CANCELLATION

SHOULD ANY OF THE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVER TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENT OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVES
HENRY M. SKIER

RECEIVED
APR 22 2010
BY

220245

RECEIVED DIRECT

RECEIVED

JENNIFER M. GRANHOLM
Governor

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
Director

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 04/23/2010

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

ADDRESS: [redacted]
Detroit MI 482350000

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

LICENSE NUMBER: 4301059142 **STATUS:** Active **EXPIRATION DATE:** 01/31/2011

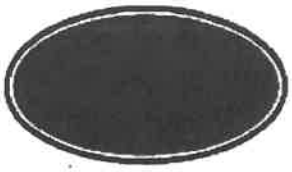
OBTAINED BY: Endorsement

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: 04/23/2010



Validation

This confirms that the licensure verification statement for Karoline Puder, was sent to you from the VeriDoc website.

Thank you for using the VeriDoc system.

Curriculum Vitae

Karoline Suzanne Puder, MD

Address:

Office:
6071 W. Outer Dr.
Detroit, MI 48235

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

Christina Markgraf • Presenter Assistant, WC866 Coordinator
570.226.4571 • fax: 570.226.1147
ChristinaM@amskier.com

MEMORANDUM

To: Commonwealth Of Pennsylvania – State Board Of Medicine

Re: Pennsylvania Temporary License for Camp Doctor

Date: 4-19-10

Name of Applicant: Dr. Karoline Puder

Name of Camp: Camp Stone

Dates of service at Camp: 6-27-10 to 7-4-10

Enclosed, please find:

- ☑ Completed Temporary License Application
- ☑ Check in the amount of $45.00
- ☑ Letter from Back-Up Physician
- ☐ Letter from Camp Director
- ☑ Current Curriculum Vitae
- ☑ Medical Malpractice Insurance Certificate

Thank you,

Christina

Christina Markgraf

RECEIVED
APR 22 2010
By

SINCE 1920 A·M·SKIER INSURANCE

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

April 29, 2010

Attn: Tammy Radel, Administrator
Pennsylvania State Board of Medicine
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: April 29, 2010
Your Reference Number: ahollinger
FSMB Batch Number: BQ1753646

The following is a report of the search results from the Board Action Data Bank as of April 29, 2010 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 29, 2010

Item	Name	DOB	School	Yr/Grad	Request ID
3	ABRONS, MITCHELL	[redacted]		1998	22185801
		LICENSE HISTORY State Board NEW YORK			
5	DOBROSKI, DAVID ROBERTSON	[redacted]		1992	22185809
		LICENSE HISTORY State Board MASSACHUSETTS NEW YORK			
4	LOWENTHAL, REBECCA	[redacted]		2002	22185805
		LICENSE HISTORY State Board OHIO			
1	MANDEL, ROBERT	[redacted]		1983	22185793
		LICENSE HISTORY State Board CALIFORNIA ILLINOIS INDIANA MICHIGAN MISSISSIPPI NEW JERSEY OHIO SOUTH CAROLINA			
2	PUDER, KAROLINE SUZANNE	[redacted]		1988	22185798
		LICENSE HISTORY State Board MICHIGAN NEW YORK			

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

[redacted]

TARGET SHEET

Board: Medicine

Licensee Full Name:
KAROLINE SUZANNE PUDER

License No:
TMD003283

[redacted]

3106129_LIC_1_04/10/2013

[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.state.pa.us

April 10, 2013

KAROLINE SUZANNE PUDER
CAMP STONE
[redacted]
SUGAR GROVE PA 16350

TEMPORARY AUTHORITY TO PRACTICE

CLASSIFICATION:	Temporary MD License Camp Physician
TEMPORARY LICENSE #:	TMD003283
DATE OF APPROVAL:	07/07/2013
EXPIRATION DATE:	07/14/2013

Signature – Temporary Practice Holder

Katie True

Commissioner
Bureau of Professional and Occupational Affairs

SEAL

7/7-7/14

(01/2012)

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

325485

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:	Month [redacted]	**SOCIAL SECURITY NUMBER:**	[redacted]
EMAIL ADDRESS:	[redacted]		
NAME OF MEDICAL SCHOOL ATTENDED:	Mt. Sinai School of Medicine		
DATE OF GRADUATION:	Month June	Day	Year 1988
CURRENT STATE LICENSE BEING USED TO APPLY FOR A TEMPORARY LICENSE IN PA:	Michigan.		

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

NAME OF ORGANIZATION:	Camp Stone		
ADDRESS:	Street [redacted]		
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

Anskier

APR 0 6 2013

LEGAL QUESTIONS

YOU MUST ANSWER THE FOLLOWING QUESTIONS.

If you answer "YES" to #2 through #7, provide complete details on a separate sheet of paper as well as certified copies of relevant documents. **Sign and date below.**

		Yes	No
1.	Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in any jurisdiction? **If yes, list the jurisdiction(s) here:** Michigan, NY	✓	
2.	Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		✓
3.	Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		✓
4.	Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		✓
5.	Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		✓
6.	Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
7.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Pennsylvania Department of State Professional Health Monitoring Program.**	[redacted]	

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine 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). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

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. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

[redacted]

Signature of Applicant

3/30/13

Date

APR [illegible] 2013

APR 0 5 2013

(01/2012)

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 in their official Board envelope.
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.

IMPORTANT INFORMATION

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

(01/2012)

CAMP VERIFICATION FORM

PENNSYLVANIA CAMP

NAME OF CAMP:	Camp Stone		
ADDRESS:	Street [redacted]		
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 7/7/13	To: Month/Day/Year 7/14/13	

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

Physician will be on call 24 hours/day during her week at Camp, for Emergency situations as well as General medical care for Campers + staff.

Physician will also run infirmary hours two times per day for non Emergency matters, i.e., sore throat, ears, rash, not feeling well, etc

Doctor will assess each case + treat or refer to outside doctor or ER if patient needs X-ray, I.V., or something the physician is not able or comfortable treating at Camp.

Physician will also prescribe medicine as needed through local pharmacy + oversee distribution of daily meds as well.

PRINTED NAME:	NANCY NEWMARK			
TITLE:	ADMINISTRATOR			
SIGNATURE:	[redacted]			
DATE:	Month 03	Day 11	Year 2013	

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: 7/7/2013	To: Month/Day/Year: 7/14/2013	

PENNSYLVANIA HEALTH CARE FACILITY, CAMP OR ORGANIZATION

NAME OF ORGANIZATION:	Camp Stone		
ADDRESS:	Street: [redacted]		
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: 3	Day: 12	Year: 2013

Curriculum Vitae

Karoline Suzanne Puder, MD

Address:

Office:
6071 W. Outer Dr.
Detroit, MI 48235

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

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY): 4/5/2013

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

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: ACE-Indemnity Insurance Company of North America	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER F:	

INSURED

Camp Stone
[redacted]
Sugar Grove, PA 16350

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 INJURY (Per person) $ BODILY INJURY (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 OFFICER/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	☐	☐	D35776850	11/1/2012	11/1/2013	$1,000,000 per occurrence; $2,000,000 per aggregate

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

For the dates of service while at camp: 07/07/2013 to 07/14/2013.

CERTIFICATE HOLDER

Dr. Karoline Suzanne Puder
Camp Stone
[redacted]
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 REPRESENTATIVES

HENRY M. SKIER
President

APR 8 2013

Magdalena Mozga • Assistant Service Director
570.226.4571 • fax: 570.226.1147
MagdalenaM@amskier.com

MEMORANDUM

To: Commonwealth of Pennsylvania – State Board of Medicine
Re: Pennsylvania Temporary License for Camp Doctor
Date: 4/5/2013

Name of Applicant: Karoline Suzanne Puder, MD

Name of Camp: Camp Stone

Dates of service at Camp: 7/7/2013 – 7/14/2013

Enclosed, please find:

- ☑ Completed Temporary License Application
- ☑ Check in the amount of $ 45.00
- ☑ Camp Verification Form
- ☑ Letter from Back-Up Physician
- ☑ Current Curriculum Vitae
- ☑ Medical Malpractice Insurance Certificate

Please email me at [redacted] with any questions.

Thank you,

Maggie Mozga

Magdalena Mozga

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES

STEVE ARWOOD
DIRECTOR

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF March 31, 2013

NAME: Karoline S Puder

BIRTHDATE: [redacted]

ADDRESS: [redacted]
Detroit MI 482350000

TYPE: Medical Doctor

ORIGINAL DATE: 03/18/1992

LICENSE NUMBER: 4301059142 **STATUS:** Active

EXPIRATION DATE: 01/31/2014

OBTAINED BY: Endorsement

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

DISCIPLINARY ACTION NONE

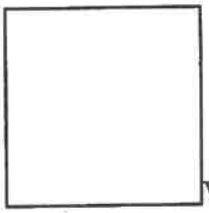
OPEN FORMAL COMPLAINTS NONE

This license information was last updated on: 3/30/2013

Semic, Cindy

From: ST, MEDICINE
Sent: Monday, April 01, 2013 9:09 AM
To: Semic, Cindy
Subject: FW: License Verification Statement - Puder, Karoline (MD)
Attachments: v150325AA.pdf

From: support@veridoc.org [mailto:support@veridoc.org]
Sent: Sunday, March 31, 2013 11:21 AM
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: 150325

Confirmation Number: 10796901911718311327

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

Welcome to VeriDoc

Home | Contact Us | FAQs | State Boards

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.

Disclaimer | Privacy Policy

325485

RECEIVED DIRECT

The Federation of State Medical Boards
of the United States, Inc.
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
FAX (817) 868-4099

BOARD ACTION CLEARANCE REPORT

April 10, 2013

Pennsylvania State Board of Medicine
Attn: Tammy Dougherty
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: April 10, 2013
Your Reference Number: AB
FSMB Batch Number: BQ2235558

The following is a report of the search results from the Board Action Data Bank as of April 10, 2013 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 10, 2013

Item	Name	DOB	School	Yr/Grad	Request ID
1	PUDER, KAROLINE SUZANNE	[redacted]		1988	26538104

LICENSE HISTORY
State Board
MICHIGAN
NEW YORK

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

[redacted]

TARGET SHEET

Board: Medicine

Licensee Full Name:
KAROLINE SUZANNE PUDER

License No:
TMD002964

2909791_LIC_1_05/26/2011

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.state.pa.us

May 26, 2011

KAROLINE SUZANNE PUDER
CAMP STONE
[redacted]
SUGAR GROVE PA 16350

TEMPORARY AUTHORITY TO PRACTICE

CLASSIFICATION:	Temporary MD License Camp Physician
TEMPORARY LICENSE #:	TMD002964
DATE OF APPROVAL:	07/03/2011
EXPIRATION DATE:	07/10/2011

Signature – Temporary Practice Holder

Katie True

Acting Commissioner
Bureau of Professional and Occupational Affairs

SEAL

49-103 (03/08)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR TEMPORARY LICENSE TMD002964

Application Fee: **$45.00** not refundable. Make check payable to the "Commonwealth of Pennsylvania." **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.

(PRINT OR TYPE) 258769

Applicant Information

Name Puder (LAST) Karoline (FIRST) Suzanne (MIDDLE)

Address [redacted] (STREET)

Southfield (CITY) MI (STATE) 48034 (ZIP CODE)

Date of Birth [redacted] Social Security Number [redacted]

Name of Medical School (s) Attended Mt. Sinai School of Medicine

Date of Graduation June 1958

Identify which state license you are using to apply for the temporary license Michigan

Name and address of Pennsylvania Health Care Facility, Camp, or Organization of Employment

Name Camp Stone

Address [redacted] (STREET)

Sugar Grove (CITY) PA (STATE) 16350 (ZIP CODE)

MAY 0 9 2011

Name and address of Attending Physician, Supervisor, or Agency Head

Name Dr. Roman Matlaga

Address [redacted] (STREET)

Honesdale (CITY) PA (STATE) 18431 (ZIP CODE)

MAY 0 9 2011

05 201

Answer the following questions. If "YES" is answered to #2 through #7, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	YES	NO
1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in any jurisdiction? **If yes, list the jurisdiction(s) here:** Michigan, NY	✓	
2) Have you ever withdrawn an application for a license, certification, or registration, had an application denied or refused, or agreed not to reapply in another state, territory or country?		✓
3) Has any disciplinary action been taken against your license, certification, or registration in another state, territory or country?		✓
4) Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?		✓
5) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		✓
6) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
7) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)**		[redacted]

MAY [redacted] 2011

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine 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). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

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. Section 4904 relating to unsworn fals[redacted] in the suspension or revocation of my license or certificate.

[redacted] 4/29/11

Signature of Applicant Date

49-103 (03/08)

MAR 30 2011

HOSPITAL, HEALTH CARE FACILITY, EMPLOYER OR CAMP VERIFICATION FORM

Name and Address of Pennsylvania Health Care Facility, Camp or organization of employment:

Name Camp Stone

Address [redacted]
Street

Sugar Grove PA 16350
City State Zip Code

Name of Temporary License Applicant Karoline S. Puder

Dates of service for the Applicant 7/3/11 - 7/10/11

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.

MAY 09 2011

Signature [redacted]

Title Administrator, Camp Stone

Date 3/23/11

49-103 (03/08)

COLLABORATING/BACK UP DOCTOR FORM

Collaborating/Back-Up Doctor's Name Roman Matlaga, DO

License Number of Collaborating/Back-Up Doctor MD 05-008779-L

Name of Temporary License Applicant Dr. Karoline S. Puder

Dates You Will Serve as the Collaborating/Back-Up Doctor 7/3/2011 to 7/10/2011

Name and Address of Pennsylvania Health Care Facility, Camp, or organization of employment:

Name Camp Stone

Address [redacted]
Street

Sugar Grove PA 16350
City State Zip Code

I Agree to Serve as the Collaborating/Back-Up Doctor for the Above Named Applicant in the Performance of the Following Listed Duties/Procedures:

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

MAY 09 2011

Signature of Collaborating/Back-Up Doctor [redacted]

Date 4/7/11

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY): 5/5/2011

PRODUCER

A. M. Skier Agency
209 Main Avenue
Hawley, PA 18428

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED NY THE POLICIES BELOW.

COMPANIES AFFORDING COVERAGE

COMPANY A: ACE-Indemnity Insurance Company of North America

INSURED

Camp Stone
[redacted]
Sugar Grove, PA 16350

COMPANY B:
COMPANY C:
COMPANY D:

COVERAGES

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.

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
	GENERAL LIABILITY				GENERAL AGGREGATE	$
	☐ COMMERCIAL GENERAL LIABILITY				PRODUCTS - COMP/OP AGG	$
	☐ CLAIMS MADE ☐ OCCUR				PERSONAL AND ADV INJURY	$
	OWNERS AND CONTRACTORS PROT				EACH OCCURRENCE	$
					FIRE DAMAGE (Any one fire)	$
					MED EXP (Any one person)	$
	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT	$
	☐ ANY AUTO				BODILY INURY (Per person)	$
	☐ ALL OWNED AUTOS					
	☐ SCHEDULED AUTOS				BODILY INURY (Per accident)	$
	☐ HIRED AUTOS					
	☐ NON-OWNED AUTOS				PROPERTY DAMAGE	$
	☐ Comp De					
	☐ Coll Ded					
	GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
	☐ ANY AUTO				OTHER THAN AUTO ONLY:	$
					EACH ACCIDENT	$
					AGGREGATE	$
	EXCESS LIABILITY				EACH OCCURRENCE	$
	☐ UMBRELLA FORM				AGGREGATE	$
	☐ OTHER THAN UMBRELLA FORM					
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATUTORY LIMITS	$
	THE PROPRIETORY/ PARTNERS/EXECUTIVE OFFICERS ARE: ☐ INCL ☐ EXCL				EL EACH ACCIDENT	$
					EL DISEASE - POLICY LIMIT	$
					EL DISEASE - EA EMPLOYEE	$
A	OTHER Professional Liability	D35776850	11/1/2010	11/1/2011	1,000,000 per occurance	2,000,000 aggregate

SINCE 1920
A·M·SKIER
INSURANCE

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHILCES/SPECIAL ITEMS

For the dates of service while at camp: 07/03/2011 to 07/10/2011.

MAY 09 2011

CERTIFICATE HOLDER

Dr. Karoline S. Puder
Camp Stone
2145 Deer Run Road
Sugar Grove, PA 16350

CANCELLATION

SHOULD ANY OF THE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVER TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENT OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVES
HENRY M. SKIER

JENNIFER M. GRANHOLM
Governor

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
Director

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 05/10/2011

NAME: Karoline S Puder

BIRTHDATE: [redacted]

ADDRESS: [redacted]
Detroit MI 482350000

TYPE: Medical Doctor

ORIGINAL DATE: 03/18/1992

LICENSE NUMBER: 4301059142 **STATUS:** Active

EXPIRATION DATE: 01/31/2014

OBTAINED BY: Endorsement

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

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

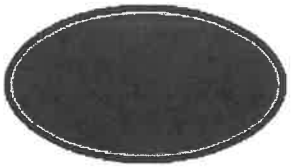
This license information was last updated on: 05/10/2011

MAY 11 2011

RECEIVED DIRECT

BUREAU OF HEALTH PROFESSIONS
611 W. OTTAWA • P.O. BOX 30670 • LANSING, MICHIGAN 48909-8170
www.michigan.gov • (517) 335-0918

25878



Home

Contact Us | FAQs | State Boards

Validation

This confirms that the MI licensure verification statement for Karoline Puder, was sent to you from the VeriDoc website.

Thank you for using the VeriDoc system.

v2

Disclaimer | Privacy Policy

MAY 11 2011

RECEIVED DIRECT

Signature: K Puder

Date: April 30, ~~2011~~

KAROLINE SUZANNE PUDER, M.D.

ADDRESS:

Office:

Department of Obstetrics and Gynecology
Sinai-Grace Hospital/Wayne State University
6071 West Outer Drive
Detroit, MI 48235
[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 – present

PROFESSIONAL APPOINTMENTS:

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

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. #929468M valid through December 31, 2011.

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

National Board of Medical Examiners Certificate # 33603564

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

49-103 (03/08)

MAY 05 2011

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.**

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 insurance company, which verifies malpractice insurance coverage at this facility during 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 in an official Board envelope.

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.

MAY 06 2011

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 your license.**
- **Failure to provide sufficient information and supporting documents may result in a processing delay or the return of your application.**

Martha Spreen • Presenter Assistant
570.226.4571 • fax: 570.226.1147
MarthaS@amskier.com

MEMORANDUM

To: Commonwealth of Pennsylvania – State Board of Medicine

Re: Pennsylvania Temporary License for Camp Doctor

Date: 5/5/2011

Name of Applicant: Dr. Karoline S. Puder

Name of Camp: Camp Stone

Dates of service at Camp: 7/3/2011 to 7/10/2011

Enclosed, please find:

- ☑ Completed Temporary License Application
- ☑ Check in the amount of $ 45.00
- ☑ Letter from Back-Up Physician
- ☑ Letter from Camp Director
- ☑ Current Curriculum Vitae
- ☑ Medical Malpractice Insurance Certificate

MAY 09 2011

Thank you,

Martha Spreen

Martha Spreen

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

May 26, 2011

Attn: Tammy Dougherty
Pennsylvania State Board of Medicine
Tammy Dougherty
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: May 26, 2011
Your Reference Number: ahollinger
FSMB Batch Number: BQ1914864

The following is a report of the search results from the Board Action Data Bank as of May 26, 2011 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 26, 2011

Item	Name	DOB	School	Yr/Grad	Request ID
2	BAR-SHAIN, DAVID SOLOMON	[redacted]		1995	23788376
		LICENSE HISTORY State Board OHIO			
4	BORISON, DANIEL ISAAC	[redacted]		1987	23788380
		LICENSE HISTORY State Board OHIO			
3	CASSIERE, HUGH ALBERT	[redacted]		1991	23788377
		LICENSE HISTORY State Board NEW JERSEY NEW YORK			
1	POLLACK, STACI ELLEN	[redacted]		1992	23788375
		LICENSE HISTORY State Board NEW YORK PENNSYLVANIA			
5	PUDER, KAROLINE SUZANNE	[redacted]		1988	23788381
		LICENSE HISTORY State Board MICHIGAN NEW YORK			

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

Bureau of Professional and Occupational Affairs
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Telephone: 7177831400
Fax: 7177877769
Website: http://www.dos.pa.gov/med
E-Mail: st-medicine@pa.gov

Courier Address:
2601 North Third Street
Harrisburg PA 17110

May 25, 2018

KAROLINE PUDER
[redacted]
Southfield Michigan 48034

TEMPORARY MD LICENSE REGISTRATION

NAME:	KAROLINE SUZANNE PUDER
CLASSIFICATION:	Temporary MD License
TEMPORARY LICENSE# :	TMD004030
DATE OF APPROVAL:	Jun 1 2018
EXPIRATION DATE:	Aug 31 2018

THIS TEMPORARY MD PRACTICE PERMIT MAY NOT BE RENEWED.

Signature - Temporary Practice Holder

Commissioner
Bureau of Professional and Occupational Affairs

Medicine- Temporary MD License-Application

AA0000567716

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649

APPLICANT INFORMATION

PERSONAL INFORMATION							
Last Name	PUDER	First Name	KAROLINE				
Middle Name	SUZANNE	Suffix					
Full Name	KAROLINE SUZANNE PUDER						
SSN	[redacted]	Date Of Birth	[redacted]	Age	54	Gender	

ADDRESS DETAILS			
Street Address	[redacted] SOUTHFIELD MI 48034		
City/State/Zip	Southfield Michigan 48034		
County	Oakland	Country	United States

CHECKLIST ITEMS

Checklist name	Status	Submitted Date	Expiration Date
Application	Pending Review	05/07/2018	
Application Fee	Not Received	05/07/2018	
Child Abuse CE	Completed	05/07/2018	
Criminal History Check	Not Received	05/07/2018	
Databank Report	Not Received	05/07/2018	
Letter from Backup Physician	Not Received	05/07/2018	
Letter of Good Standing (LOGS)	Not Received	05/07/2018	
Malpractice Insurance	Not Received	05/07/2018	
OPIOID CE	Not Received	05/07/2018	
Position Verification	Not Received	05/07/2018	
Resume/Curriculum Vitae	Not Received	05/07/2018	
SSN Waiver	Not Received	05/07/2018	

CONFIRMATION

☑ All fees are non-refundable. Please check to continue with your transaction. (05/07/2018 10:56:40)

(8/2017)

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 Karolina	Middle Suzanne
ADDRESS:	Street [redacted]		
City Southfield		State MI	ZIP 4803[redacted]
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 06	Day 15	Year 1988
CURRENT STATE LICENSE BEING USED TO APPLY FOR A TEMPORARY LICENSE IN PA:	MI 4301 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 CRUSE	First JAMES	Middle GARLAND
ADDRESS:	Street [redacted]		
City: HONESDALE		State PA	ZIP 18431

APR 17 2018

By

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 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 in a health-related profession in any state or jurisdiction? **If you answered yes, provide the profession and state or jurisdiction.** **LIST:** MD - MT → NY	✓	
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 othe[redacted] drugs or substances that may impair judgment or coordination?		
12	Since May 19, 2002, 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-NI	✓	Karwick. 2015, 2016, 2017

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. § 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

4/8/18

Date

Karoline Porter MD

Printed Name of Applicant

APR 17 2018

(8/2017)

PENNSYLVANIA STATE BOARD OF MEDICINE

HOSPITAL, HEALTH CARE FACILITY, EMPLOYER OR CAMP VERIFICATION FORM

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME OF APPLICANT:	Last	First	Middle
	Puder	Karoline	Suzanne

Submit this form to the Pennsylvania Hospital, Health Care Facility, Employer or Camp for completion of Section 2. The organization should return the completed form to you for submission.

SECTION 2 – TO BE COMPLETED BY THE PENNSYLVANIA HOSPITAL, HEALTH CARE FACILITY, EMPLOYER, OR CAMP

NAME OF ORGANIZATION:	Midwest Campers, Inc.		
ORGANIZATION ADDRESS:	Street: 2145 Deer Run Road		
City: Sugar Grove		State: PA	Zip: 16350
DATES OF SERVICE FOR APPLICANT:	From: Month/Day/Year: 6/1/2018	To: Month/Day/Year: 8/31/2018	

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 Manager
SIGNATURE:				Randi Mashmoor
DATE:	Month: 2	Day: 12	Year: 2018	Upon completion, please return this completed form to the applicant.

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

PENNSYLVANIA STATE BOARD OF MEDICINE

COLLABORATING/BACK-UP PHYSICIAN FORM

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME OF APPLICANT:	Last	First	Middle
	Puder	Karoline	Suzanne

Submit this form to your collaborating/back-up physician for completion of Section 2. The collaborating/back-up physician should return the completed form to you for submission.

SECTION 2 – TO BE COMPLETED BY THE COLLABORATING OR BACK-UP PHYSICIAN

NAME OF COLLABORTING/BACK-UP PHYSICIAN:	Last	First	Middle
	Cruse	James	Garland

PENNSYLVANIA LICENSE NUMBER:	MD451558
NAME OF ORGANIZATION:	Midwest Campers, Inc.
ORGANIZATION ADDRESS:	Street: 2145 Deer Run Road

City	State	Zip
Sugar Grove	PA	16350

DATES YOU WILL SERVE AS THE COLLABORATING/BACK-UP PHYSICIAN:	From: Month/Day/Year	To: Month/Day/Year
	06/01/2018	08/31/2018

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. Referring to specialist if a medical problem is beyond his/her expertise or ability.

[redacted]

SIGNATURE OF COLLABORATING/BACK-UP PHYSICIAN:				
DATE:	Month: 02	Day: 20	Year: 2018	Upon completion, please return this completed form to the applicant.

Regular Mailing Address	Courier Delivery Address
STATE BOARD OF MEDICINE **P.O. BOX 2649** **HARRISBURG, PA 17105-2649** **717-783-1400**	**STATE BOARD OF MEDICINE** **2601 NORTH THIRD STREET** **HARRISBURG, PA 17110**

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY): 4/13/2018

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

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Markel Insurance Company	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER F:	

INSURED

Midwest Campers, Inc.
[redacted]
Sugar Grove, PA 16350

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						EACH OCCURRENCE $
	COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence) $
	CLAIMS MADE OCCUR						MED EXP (Any one person) $
							PERSONAL AND ADV INJURY $
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE $
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG $
							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT $
	ANY AUTO						BODILY INJURY (Per person) $
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident) $
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE $
							Deductible: $
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE $
	EXCESS LIAB CLAIMS-MADE						AGGREGATE $
	DED RETENTION $						
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	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			8502CY4190023	11/1/2017	11/1/2018	1,000,000 per occurance; 5,000,000 aggregate

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

For the dates of service while at camp: 6/1/2018 - 8/31/2018.

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CERTIFICATE HOLDER

Dr. Karoline Suzanne Puder
Midwest Campers, Inc.
[redacted]
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 REPRESENTATIVE

HENRY M. SKIER
President

Signature: [redacted]

Date: April 8, 2018

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

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

APR 17 2018

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, 2017. #929468M valid through December 31, 2018.

American Board of Obstetrics and Gynecology, 1996. Recertification 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017. #929468M valid through December 31, 2018.

National Board of Medical Examiners Certificate # 33603564

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

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

MEMORANDUM

To: Commonwealth of Pennsylvania – State Board of Medicine

Re: **Pennsylvania Temporary License for Camp Doctor**

Date: April 13, 2018

Name of Applicant: Dr. Karoline Suzanne Puder, MD

Name of Camp: Midwest Campers

Dates of service at Camp: 06/01/2018 – 08/31/2018

Please forward a copy of any discrepancy letter to [redacted]

Just like in the past, when the temporary license gets issued, please mail it to:

AMSkier, 209 Main Avenue, Hawley, PA 18428, Attn: Maggie

Thank you,

Magdalena Mozga

SINCE 1920 A·M·SKIER INSURANCE

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By

(8/2017)

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 are an Osteopathic Physician, please use the application under the Osteopathic Board.**
- **If you previously held a Pennsylvania Unrestricted License, you cannot apply for a Temporary License and must reactivate your Unrestricted License.**

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.	Complete Section 1 of the Hospital, Health Care Facility, Employer or Camp Verification Form. Arrange for the hospital, health care facility, employer or camp to complete Section 2.
3.	Complete Section 1 of the Collaborating/Back-Up Physician Form and submit to the collaborating/back-up physician for completion of Section 2.
4.	Submit a letter from an insurance company which verifies malpractice insurance coverage at the organization 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. The letter must include the following: license issue and expiration date, license status (current or expired) and disciplinary standing. The letter of good standing must be sent **directly** to the 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.
9.	Section 9.1(a) of ABC-MAP* requires that all prescribers or dispensers, as defined in Section 3 of ABC-MAP, applying for licensure/approval complete at least 4 hours of Board-approved education consisting of 2 hours in pain management or the identification of addiction and 2 hours in the practices of prescribing or dispensing of opioids. Applicants seeking licensure/approval on or after July 1, 2017 must document, within one year from issuance of the licensure/approval, that they completed this education either as part of an initial education program, a stand-alone course from a Board-approved course provider, or a continuing education course from an approved continuing education provider. The 4 hours of Board-approved education needs to be completed only once. See the Board's website for the Opioid Education forms and additional information. *The Achieving Better Care by Monitoring All Prescriptions Program Act (ABC-MAP) (Act 191 of 2014, as amended) is available on the Legislature's website at: http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2014&sessInd=0&smthLwInd=0&act=191

IMPORTANT INFORMATION

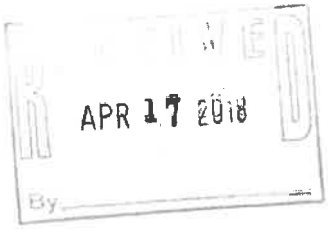
Please allow 60 days for processing of this application.

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.

EFFECTIVE JAN. 1, 2017, ACT 191 OF 2014 REQUIRES ALL PRESCRIBERS AND DISPENSERS TO REGISTER FOR THE PENNSYLVANIA PRESCRIPTION DRUG MONITORING PROGRAM (PA PDMP). PRESCRIBERS ARE REQUIRED TO QUERY THE PA PDMP SYSTEM FOR EACH PATIENT THE FIRST TIME THE PATIENT IS PRESCRIBED A CONTROLLED SUBSTANCE BY THE PRESCRIBER, WHEN THERE IS CLINICAL CONCERN THAT THE PATIENT MAY BE ABUSING OR DIVERTING A CONTROLLED SUBSTANCE(S), AND/OR EACH TIME THE PATIENT IS PRESCRIBED AN OPIOID DRUG PRODUCT OR A BENZODIAZEPINE. TO LEARN MORE AND TO REGISTER, PLEASE VISIT WWW.DOH.PA.GOV/PDMP.



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04/13/2018
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A·M·SKIER
INSURANCE

AMSkier/209 Main Avenue, Hawley, PA 18428
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State Board of Medicine
TEMPORARY LICENSE
PO Box 2649
Harrisburg, PA 17105-2649

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LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF April 08, 2018

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: 01/31/2020

OBTAINED BY: Endorsement

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

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

This verification was produced by VeriDoc on behalf of the State of Michigan with license information last updated on: 4/7/2018.

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By

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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.

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Anderson, L'Oreal

From:	ST, MEDICINE
Sent:	Monday, April 9, 2018 7:29 AM
To:	Anderson, L'Oreal
Subject:	FW: License Verification Statement - Puder, Karoline (MD)
Attachments:	v546046AA.pdf

From: support@veridoc.org [mailto:support@veridoc.org]
Sent: Sunday, April 8, 2018 4:34 PM
To: ST, MEDICINE <ra-medicine@pa.gov>
Subject: License Verification Statement - Puder, Karoline (MD)

VeriDoc

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: 546046

Confirmation Number: 14115412853131203236

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

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

PA

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, PUDER KAROLINE SUZANNE
was issued license/certificate number 179533 for the practice of MEDICINE on 08/16/1989.

Our records also indicate the following information:
Date of birth: [redacted]
School attended: MT SINAI SCHOOL MEDICINE
Date of graduation: 05/17/88
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:
NAT BD CERT #360386 DATED 07/03/89

A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 08/31/20
Address: [redacted] SOUTHFIELD MI 48034-0000

Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Cathy Hanczaryk, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SE

Cathy Hanczaryk 04/25/18
Office Assistant Three

PLS295.545206

NEW YORK STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

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P.O. BOX 2649
HARRISBURG, PA 17105-2649

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