STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
Susan Miller
Program Administrator

1560 Broadway, Suite 1300
Denver, CO 80202-5140
(303) 894-7690

Department of Regulatory Agencies
Joseph A. Garcia
Executive Director

Division of Registrations
Bruce M. Douglas, Director

Roy Romer
Governor

May 24, 1996

Ruth K. Rutberg, M.D.
7516 19th Ave N.E.
Seattle, Washington 98115

35265

Dear Dr. Rutberg:

At a meeting of the Colorado Board of Medical Examiners held on May 16, 1996, your application for Colorado medical licensure was approved.

Your license number is 35265, effective May 16, 1996.

All physician licenses expire during May of each odd numbered year, and once renewed are good for a two year period. Your license will expire May 31, 1997 - please note this date. Notice of the renewal fee will be sent to you at the last address of record in our files. It is important to inform the Board of any changes in work or home address in order to ensure that your renewal packet will reach you in a timely manner. A second renewal notice is not required by law. It is the responsibility of each physician to remit the registration fee to this office, even though the original notice fails to reach the physician. The Board cannot assume responsibility for changes of address that do not reach its office.

Sincerely,

FOR THE BOARD OF MEDICAL EXAMINERS

Rose Gotseff
Office Manager

1985

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations BOARD OF MEDICAL EXAMINERS

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690 V/TDD (303) 894-7880

APR 2 9 1996

BOARD OF MEDICAL EXAMINERS FEB 2 8 1996 STATE OF COLORADO

RADH 1985

STATE OF COLORADO

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE

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

OFFICE USE ONLY

1a. Name: Last: Rutberg First: Ruth Middle: Kibbee Degree: MD

1b. Social Security Number: REDACTED

PERSONAL DATA

2. Other names - indicate if none.

Ruth K. Weinberg-maiden name

L7 ☒

3. Mailing Address: Number and Street/Rural Route, Apartment Number

7516 19th Ave NE

City: Seattle State: Washington Zip: 98115 Country: USA

4. Telephone Number: (Area Code) Day Evening

(206) 527-4164

5. Date of Birth: Mo/Day/Year REDACTED Place of Birth: Chicago, Illinois

Submit a certified or notarized copy of your birth certificate or passport.

6. Sex

Male (Female)

7. Have you ever filed an application in Colorado? ☐ Yes ☒ No

If yes, give date of previous application

8. List name and address of all colleges or universities where pre-medical instruction was received. Pre-medical instructions is limited to that course work required for entrance to medical school.
Request an official copy of transcript, with seal of school affixed to be sent directly from school to this office.
If transcript are not in English, send a certified English Translation

PRE-MED EDUC

Name of School	Address and zip	Period of attendance From (Mo/Yr)	Period of attendance To (Mo/Yr)
Stanford University	Stanford, CA 94305	9/83	6/88

☒ ☐ ☐

9. List name and address of all schools where professional medical instruction was received.
Request an original L2 Form (Certificate of Medical Education) and an official copy of transcripts, with seal of school affixed, from each school attended.
Certificate and transcript must be sent directly from the school to this office.
If transcript are not in English, send a certified English Translation

MEDICAL EDUC
CME ☒

Name of School	Address and zip	Period of attendance From (Mo/Yr)	Period of attendance To (Mo/Yr)	Degree Granted
Univ. of Washington	Seattle, WA 98195	10/88	6/92	☒ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

☒ ☐ ☐ ☐

License # 35765 Date 5/16/96

Fee$ 322. Date 2/28/96

Org. 8/86
Revised 9/92
Revised 11/95

L1A

OFFICE USE ONLY

10. Have you taken any of the following written examinations: National Boards, ECFMG, FLEX, LMCC, USMLE, or state written exam? [X] Yes [ ] No

If yes, request certification of scores from each examination agency to be sent directly from examination agency to this office. (See "Summary of Requirements") Provide photocopy of ECFMG Certificate if applicable. Provide information below:

Exam	Location	Date	Result
NBME - I	Univ. of Wash.	June 1990	REDACTED
NBME - II	Univ. of Wash.	September 1991	
NBME - III	Univ. of Wash.	March 1993	

WRITTEN EXAM

11. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian facilities?
[X] Yes [ ] No

If yes, provide information below. Request an original L3 Form (Certificate of Completion of ACGME/AOA Postgraduate Training) from each facility attended for internship and residency training.

Name of facility	Address and zip	Specialty	Period of attendance: From (Mo/Yr)	To (Mo/Yr)
Univ. of Washington Medical Center	OB GYN Box 356460 Seattle,WA 98195	OB/GYN	7/92	6/96

POSTGRAD TRAINING

12. Are you now or have you ever been licensed to practice medicine in any state, territory, district, or country?
[X] Yes [ ] No Include temporary licenses and instructional permits. Request verification from each to be sent to the Colorado Board. See Instructions **If yes, provide information below:**

State or country	License number	Date of issue	Dates of practice in this jurisdiction: From (Mo/Yr)	To (Mo/Yr)
Washington	MD00032317	11/16/94	6/92	present

LICENSE DATA

13. Are you now or have you ever practiced medicine in any state, territory, district, or country, U.S. military, U.S. Public Health, or any U.S. government agency? (See L6 Form) [X] Yes [ ] No

L6

14. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been cancelled or rated at a higher premium due to past claims experience? No If yes explain on a separate sheet and provide verification of same from insurance company or state licensing board.

15. Have you ever been notified by any state, territory, district, country, U.S. government agency, state medical/osteopathic board of **any complaint** against you relative to your license to practice medicine? This includes, but is not limited to, any allegations currently pending. [ ] Yes [X] No

If yes, give details below:

State	Date	Charge	Disposition

REQ REC

16. Has **any disciplinary action** ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. military, U.S. Public Health Service, or other U.S. federal governmental entity. (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations currently pending.) [ ] Yes [X] No

If yes, give details below.

State or government agency	Date	Charge	Disposition

REQ REC

OFFICE USE ONLY

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

☐ Yes ☒ No

If yes, give details below:

State or government agency	Date	Reason for denial

LICENSE DATA (continued)

REQ ☐ REC ☐
☐ ☐

18. Have you ever voluntarily surrendered a license to practice in the healing arts in any other state? This does not include allowing your license to lapse solely due to payment of the renewal fee.

☐ Yes ☒ No

If yes, explain on a separate sheet. Summarize below:

State	Date	Reason for surrender

REQ ☐ REC ☐
☐ ☐

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

☐ Yes ☒ No

If yes, explain on a separate sheet. Provide a copy of letter of resignation or hospital action. Summarize details below:

Name of facility	Address and zip	Date	Reason for Action

REQ ☐ REC ☐
☐ ☐

GENERAL DATA

20. Within the last five years, have you engaged in any behavior or experienced any mental or physical health condition that might impair your ability to practice medicine safely and competently?

REDACTED

If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of behavior or condition involved, and what if anything has been done to correct the behavior or condition.

REQ ☐ REC ☐

21. Within the last five years, have you illegally or excessively used any controlled substance, habit forming drug, prescription medication, or alcohol?

REDACTED

If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of behavior involved, and what if anything has been done to correct the behavior.

REQ ☐ REC ☐

22. Have you ever received a deferred prosecution, a deferred judgement, been convicted of, or pled guilty or **nolo contendere** to a violation of any federal, state, or local law relating to the manufacture, distribution or dispensing of controlled substances, or relating to drug abuse, including alcohol?

☐ Yes ☒ No

If yes, explain on a separate sheet. Summarize below:

Date	Court address and zip	Violation	Penalty or disposition

REQ ☐ REC ☐
☐ ☐

23. Have you ever received a deferred prosecution, a deferred judgement, been convicted of or pled guilty or **nolo contendere** to, any felony in any state, territory, district, the United States, or a foreign country?

☐ Yes ☒ No

If yes, give details below; include any conviction that has been set aside, dismissed, or pardoned under the Constitution of Colorado, article IV, section 7, or under any other provision of law.

Date	Court address and zip	Violation	Penalty or disposition

REQ ☐ REC ☐
☐ ☐

24. You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado law, or claim one of the seven exemptions set forth in the enclosed insurance memo. See instructions in application packet, and include proof of insurance (obtained from your insurance carrier) or include a statement setting forth the basis for an exemption applicable at the time you submit your application.

INS ☒

I hereby declare under penalty of perjury under the laws of the State of Colorado, that the photo of myself attached hereto, was taken

on or about February 11, 19 96,

my age then being 30 years;

color of hair Light brown;

color of eyes Blue;

height 5 ft. 6 in. ______;

weight 150 lbs.;

identifying marks None

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

I, Ruth Kibbee Rutberg hereby make application for a license to practice medicine in the State of Colorado.

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

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

I state under penalty of perjury in the second degree, as defined in 18-8-503, Colorado Revised Statutes, that the information contained in this application is true and correct to the best of my knowledge.

I understand that under the Colorado Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

Ruth K. Rutberg
Signature

2/19/96
Date

L1D

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690, V/TDD (303) 894-7880

RECEIVED
FEB 2 8 1996
REGISTRATION-SCHEDULING

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW.

This certifies that Ruth Kibbee Rutberg (formerly Ruth Kibbee Weinberg)
FULL NAME OF APPLICANT

of 7516 19th Ave NE Seattle,WA 98115 enrolled in University of Washington
ADDRESS WHEN ENROLLED — NAME OF MEDICAL SCHOOL

Seattle, WA on the ~~26th~~ 19th day of ~~October~~ September 19 88
LOCATION — MONTH — YEAR

and was granted the following credits on enrolment:

Course of study	Institution	Date completed	Credit awarded

BOARD OF MEDICAL EXAMINERS
MAR - 5 1996
STATE OF COLORADO

The undersigned further certifies that the records of this institution show that she attended in this institution * ______ (number of weeks) of resident instruction, and that: Dr. Rutberg completed a full course of study as approved by the LCME.

☒ s/he was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy, or
☐ s/he withdrew from
the above mentioned medical/osteopathic school on the 12th day of June, 19 92

Signed and the college seal affixed this 28th day of February, 19 96.

BY Trudy L. Furberry
Trudy L. Furberry, PRESIDENT, SECRETARY, DEAN Certifying Officer

NOTES TO REGISTRAR AND APPLICANT

1. Medical School Seal **MUST** Be Imprinted Partially on the Photograph.
2. TRANSCRIPTS OF MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE.
3. Each school where professional medical instruction was received **MUST** complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to the form must be original.

NOT VALID WITHOUT SCHOOL SEAL

If no school seal please indicate above next to signature of President/Secretary/Dean.

L2

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690, V/TDD (303) 894-7880

MAR 18 1996

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

TO BE COMPLETED BY THE FACILITY FOR EVERY MEDICAL/OSTEOPATHIC SCHOOL GRADUATE COMPLETING POSTGRADUATE TRAINING IN THE UNITED STATES OR CANADA. **DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT IS NOT ATTACHED BELOW.** PLEASE TYPE OR PRINT.

This is to certify that Ruth Kibbee Rutberg
NAME OF APPLICANT

a graduate of University of Washington School of Medicine
NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in OB/GYN Box 356460
NAME AND ADDRESS OF FACILITY
University of Washington Medical Center
Seattle, WA 98195

on July 1, 1992, and REDACTED training

on June 30, 1996. This training consisted of ______ months of actual clinical instruction and is approved by the Accredited Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

List type and length of training.

ROTATION	LENGTH OF ROTATION

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

REDACTED

IF NO, PLEASE ATTACH AN EXPLANATION.

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

NAME MORTON A. STENCHEVER, MD
PROGRAM DIRECTOR

(AFFIX INSTITUTIONAL SEAL) **NOT VALID WITHOUT SEAL**

ADDRESS DEPT OB/GYN, UNIV. of WASHINGTON
SEATTLE, WASH, 98195

PHONE NUMBER (206)-543-3045

DATE 3/4/96

SIGNATURE [signature], MD

L3

- Board of Osteopathic Medicine & Surgery
- Certified Respiratory Care Practitioners
- Health Care Assistants
- Medical Quality Assurance Commission
- Podiatric Medical Board
- Radiologic Technology Program

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
HEALTH PROFESSIONS SECTION FIVE
1300 SE Quince St, MS 7866 • Olympia, WA 98504-7866

BOARD OF MEDICAL EXAMINERS
FEB 20 1996
STATE OF COLORADO

February 13, 1996

State of Colorado Medical Examiners
1560 Broadway Suite 1300
Denver, CO 80202

I, Betty Elliott, Public Disclosure Officer, do hereby certify that a standard search of the available records of the Medical Quality Assurance Commission indicates the following:

PHYSICIAN'S NAME	**Ruth Rutberg, MD**
LICENSE NUMBER:	**MD32317**
ISSUE DATE:	**11-16-94**
EXPIRATION DATE:	**1-5-97**
DATE OF BIRTH:	REDACTED

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED

If our records above show that the license has been disciplined, photocopies from the public file are available upon written request. Send request to Medical Quality Assurance Commission, P.O. Box 47866, Olympia, WA 98504-7866.

The information above is the only certification information by the Commission. to expedite the certification process, the above format is the standard format prepared for all professions regulated by this Commission. If you have any questions, please contact me at (360)664-8691.

Sincerely,

Betty Elliott
Betty Elliott
Public Disclosure Coordinator

(SEAL)

BOARD OF MEDICAL EXAMINERS

MAY 20 1996

STATE OF COLORADO

May 15, 1996

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

Dear Sirs,

My application for medical licensure in Colorado is being evaluated by your board.

I was recently notified of a complaint filed May 6, 1996 to the State of Washington Medical Quality Assurance Commission. I'm enclosing a copy of the letter I received. I've been given no other information.

Please contact me if there is any more information that you need.

Sincerely,

Ruth K Rutberg MD
Ruth K Rutberg

BOARD OF MEDICAL EXAMINERS

MAY 20 1996

STATE OF COLORADO

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

May 8, 1996

Ruth R. Rutberg, MD
7516 19th Ave., NE
Seattle, WA 98115

RE: Case Number: 96-05-0015MD

Dear Dr. Rutberg:

The purpose of this letter is to inform you that the Medical Quality Assurance Commission has received a complaint dated May 6, 1996, concerning an allegation of performing a surgical procedure without the patient's full consent.

Under the provision of RCW 18.130.050, the Uniform Disciplinary Act, the Medical Quality Assurance Commission is the agency within the State government with legislated authority to accept and investigate complaints concerning physicians and physician assistants.

Commission staff have reviewed the complaint and concluded that the allegations made in the complaint fall within the jurisdiction of the Medical Quality Assurance Commission. A case file has been opened under the case number 96-05-0015MD. A preliminary investigation to gather the facts will be conducted by an investigator from the Department of Health, Medical Investigations Unit. The investigator will contact you as soon as possible during the investigation.

Attached for your information, is an explanation of the Medical Quality Assurance Commission's complaint process. If you have questions, please feel free to call James H. Smith, Chief Investigator at (360) 586-4574.

Respectfully,

Maryella Jansen

Maryella Jansen, Program Manager
(360) 664-0244

Attachment

STATE OF COLORADO

Department of Regulatory Agencies
Division Of Registration

SEE INSTRUCTIONS ON REVERSE

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690 V/TDD (303) 894-7880

REPORT OF PRACTICE HISTORY
ORIGINAL LICENSURE

	Facility Name	Address and Zip	Reference (name & title)	Dates of Practice From – To	Nature of Practice
1.	UWMC	OB/GYN Box 356460 Seattle, WA 98195-6464	Louis Vontver, MD Residency Administrative Dir.	7/92- present	4-year OB/GYN Residency
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

BOARD OF MEDICAL EXAMINERS
FEB 28 1996
STATE OF COLORADO

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

I state under penalty of perjury in the second degree, as defined in 18-8-503, Colorado Revised Statutes, that the information contained in this application is true and correct to the best of my knowledge.

I understand that under the Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

Ruth K Rutberg — SIGNATURE

Rutberg — PRINT LAST NAME

2/19/96 — DATE

L6

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

BOARD OF MEDICAL EXAMINERS
FEB 12 1996
STATE OF COLORADO

Diplomate Name: Ruth Kibbee Weinberg, MD

Date of Birth: REDACTED

Certification Date: 07/01/1993

Certificate #: 412478

REDACTED

DATE: 02/07/1996

SEE OTHER SIDE FOR SCORE INFORMATION

PLEASE PRINT OR TYPE

LAST NAME	FIRST NAME	MI	LICENSE #	SOCIAL SECURIT
Rutberg	Ruth	K	35265	REDACTED

BOTH SIDES OF THIS FORM MUST BE TOTALLY AND ACCURATELY COMPLETED OR IT WILL BE RETURNE TO YOU AND WILL DELAY YOUR RENEWAL.

Read both sides carefully before you begin. Make a copy for your records.

COLORADO BOARD OF MEDICAL EXAMINERS 1997 LICENSE RENEWAL QUESTIONNAI

The Colorado Medical Practice Act mandates that a questionnaire be mailed to, and completed by, each physician wishing to renew h license at the time of expiration. **COMPLETION OF THIS QUESTIONNAIRE IS NOT OPTIONAL**. Each question must be answered. Answering "yes" to any of these questions **will not** automatically delay renewal of your license.

A) Since you last renewed your Colorado medical license, have you: **YES** **N**

1. had any adverse action taken against you by any licensing agency in another state or country, any peer review body, any health care institution, any professional or medical society or association, any governmental agency, any law enforcement agency, or any court? ☐ [
2. surrendered a license or other authorization to practice medicine in another state or jurisdiction or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies? ☐ [
3. had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? (Note: Please include any payments you have personally made.) ☐ [
4. been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier? ☐ [

B) Since you last renewed your Colorado medical license, have either of the following been denied, revoked, suspended, reduced, lim placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "yes" to the items below if any of thes same actions are currently pending. (Note: You must answer yes if you have withdrawn or failed to proceed with an application fo of these items.)

5. Medical staff membership or clinical privileges at any hospital or health care institution? ☐ [
6. DEA registration? ☐ [

C) Since you last renewed your Colorado license, have you:

7. had any felony or misdemeanor charges, or any traffic citations involving drugs or alcohol, brought against you? ☐ [
8. illegally or excessively used any controlled substance, habit forming drug, prescription medication, or alcohol? You need not report behavior which is already known to the Colorado Board of Medical Examiners or the Colorado Physician Health Program REDACTED
9. engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine safely and competently? You need not report behavior or conditions which are already known to the Colorado Board of Medical Examiners or the Colorado Physician Health Program REDACTED

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, PLEASE PROVIDE THE FOLLOWING INFORMATION. IF YOU NEED TO ATTACH ANOTHER SHEET OF PAPER OR DOCUMENTS, PLEASE PUT YOUR NAME AND LICEN NUMBER ON EACH ATTACHMENT.

Questions 1 and 2: Indicate name and address of the entity taking the action or investigating conduct/allegations, the date of the action specify conduct/allegations upon which the action or investigation was initiated. Please include documentation of any charges and/or f action.

Questions 3 and 4: Indicate name and address of insurance carrier, reasons for action, and date of alleged conduct. Attach copy of no cation from carrier.

Questions 5 and 6: Indicate name and address of facility or organization, date of action, and specific conduct/allegations upon which action was taken. Attach a copy of notification from agency or organization taking action.

Question 7: Indicate name and address of court of jurisdiction, violation charged, date of alleged violation, and disposition of each vi tion charged.

Questions 8 and 9: Provide description of condition, date of onset, dates and summary of any treatment, name and address of all trea providers, and current status of condition.

– OV]

1997 RENEWAL INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility.

☐ **I WISH TO CHANGE FROM INACTIVE TO ACTIVE STATUS: FEE - $195.** You must complete a different form. Please call the Board Office at (303) 894-7719 to request a Reactivation Form.

☒ **ACTIVE LICENSE: FEE - $195.** I wish to renew my license via ACTIVE STATUS. I meet (or claim exemption from) the financial responsibility standards as indicated below: **You must check at least one.**

☒ 1. I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year.

Company: COPIC ☒ **Doctors Company** ☐ **St. Paul** ☐ **Other (Specify ________________)**

NOTE: Please supply your insurance policy number: REDACTED

☐ 2. I am covered by individual commercial professional liability insurance maintained by an employer/contracting agency in accordance with the requirements noted in "1" above.

☐ 3. I am a federal civilian or military physician whose practice is limited solely to that required by my federal or military agency.

☐ 4. I am a public employee whose practice is limited solely to that covered by the Colorado Governmental Immunity Act.

☐ 5. I do not engage in any patient care whatsoever within the state of Colorado, including prescribing. I am, however, engaged in active medical practice in another state or foreign jurisdiction. (NOTE: You may wish to consider renewing your license via inactive status - see below).

☐ 6 .My medical practice does not involve any patient care whatsoever (e.g., administrator, researcher, academician, non-medical endeavor. (NOTE: You may wish to consider renewing your license via inactive status - see below.)

☐ 7. I provide limited or occasional, uncompensated care to patients and I do not otherwise provide any compensated patient care whatsoever.

☐ 8. I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance:

☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

NOTE: The Commissioner of Insurance approves alternatives for financial responsibility. Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used. The address of the Commission Office is: 1560 Broadway, Suite 850, Denver, Colorado 80202: (303) 894-7499.

☐ **INACTIVE LICENSE: FEE: $100.** I wish to renew my license via INACTIVE STATUS. (NOTE: this category is primarily intended for retired physicians and those practicing outside Colorado.) Malpractice insurance is not required for inactive license holders. **I understand that I may not practice medicine, including prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license. I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional $95.00. I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.**

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

[signature]	3/19/97	(303) 440-3141	
Signature of Physician	Date	Phone #	Fax ##

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee, and 3) the Physician Survey (optional) in the enclosed return envelope. Direct questions to: **(303) 894-7690 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver, CO 80202-5140**

COLORADO BOARD OF MEDICAL EXAMINERS 1999 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	M	SOCIAL SECURITY #	COLORADO 5 DIGIT LICENSE #
Weinberg	Ruth Kibbee		REDACTED	35265

Instructions: Print or type name and Social Security Number and license number above. Fill in the circle that corresponds to each number of your license number.

BOTH SIDES OF THIS FORM MUST BE TOTALLY AND ACCURATELY COMPLETED OR IT WILL BE RETURNED TO YOU AND WILL DELAY YOUR RENEWAL.
Read both sides carefully before you begin. **Make a copy for your records.**

The Colorado Medical Practice Act mandates that a questionnaire be mailed to, and completed by, each physician wishing to renew his/her license at the time of expiration. **COMPLETION OF THIS QUESTIONNAIRE IS NOT OPTIONAL.** Each question must be answered. Answering "yes" to any of these questions **will not** automatically delay renewal of your license.

	YES	NO
A) Since you last renewed your Colorado medical license, have you:		
1. had any adverse action taken against you by any licensing agency in another state or country, any peer review body, any health care institution, any professional or medical society or association, any governmental agency, any law enforcement agency, or any court?	☐	☑
2. surrendered a license or other authorization to practice medicine in another state or jurisdiction or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?	☐	☑
3. had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? (Note: Please include any payments you have personally made.)	☐	☑
4. been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier?	☐	☑
B) Since you last renewed your Colorado medical license, have either of the following been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "yes" to the items below if any of these same actions are currently pending. (Note: You must answer yes if you have withdrawn or failed to proceed with an application for any of these items.)		
5. Medical staff membership or clinical privileges at any hospital or health care institution?	☐	☑
6. DEA registration?	☐	☑
C) Since you last renewed your Colorado license, have you:		
7. had any felony or misdemeanor charges, or any traffic citations involving drugs or alcohol, brought against you?	☐	☑
8. illegally or excessively used any controlled substance, habit forming drug, prescription medication, or alcohol? You may answer NO if the behavior is already known to the Colorado Physician Health Program	REDACTED	
9. engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine safely and competently? You may answer NO if the behavior or conditions are already known to the Colorado Physician Health Program		

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, PLEASE PROVIDE THE FOLLOWING INFORMATION. IF YOU NEED TO ATTACH ANOTHER SHEET OF PAPER OR DOCUMENTS, PLEASE PUT YOUR NAME AND LICENSE NUMBER ON EACH ATTACHMENT.

Questions 1 and 2: Indicate name and address of the entity taking the action or investigating conduct/allegations, the date of the action and specify conduct/allegations upon which the action or investigation was initiated. Please include documentation of any charges and/or final action.

Questions 3 and 4: Indicate name and address of insurance carrier, reasons for action, and date of alleged conduct. Send copy of final action, amount of settlement, copy of report from National Practitioner Data Bank and a clinical narrative of the case, including patient's name.

Questions 4: Attach copy of notification from insurance carrier.

Questions 5 and 6: Indicate name and address of facility or organization, date of action, and specific conduct/allegations upon which action was taken. Attach a copy of notification from agency or organization taking action.

Question 7: Indicate name and address of court of jurisdiction, violation charged, date of alleged violation, and a copy of the final disposition of each violation charged.

Questions 8 and 9: Provide description of condition, date of onset, dates and summary of any treatment, name and address of all treatment providers, and current status of condition.

– OVER –

1999 RENEWAL INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are complying with the requirement to maintain financial responsibility.

☐ **I WISH TO CHANGE FROM INACTIVE TO ACTIVE STATUS: FEE - $305.** You must complete a different form. Please call the Board Office at (303) 894-7719 to request a Reactivation Form.

☑ **ACTIVE LICENSE: FEE - $305.** I wish to renew my license via ACTIVE STATUS. I meet (or claim exemption from) the financial responsibility standards as indicated below: **You must check at least one.**

☑ 1. I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year.

Company: COPIC ☑ **Doctors Company** ☐ **St. Paul** ☐ **Other (Specify________________)**

NOTE: Please supply your insurance policy number: REDACTED

☑ 2. I am covered by individual commercial professional liability insurance maintained by an employer/contracting agency in *accordance with the requirements noted in "1" above.*

☐ 3. I am a federal civilian or military physician whose practice is limited solely to that required by my federal or military agency.

☐ 4. I am a public employee whose practice is limited solely to that covered by the Colorado Governmental Immunity Act.

☐ 5. I do not engage in any patient care whatsoever within the state of Colorado, including prescribing. I am, however, engaged in active medical practice in another state or foreign jurisdiction. (NOTE: You may wish to consider renewing your license via inactive status - see below).

☐ 6 .My medical practice does not involve any patient care whatsoever (e.g., administrator, researcher, academician, non-medical endeavor. (NOTE: You may wish to consider renewing your license via inactive status - see below.)

☐ 7. I provide limited or occasional, uncompensated care to patients and I do not otherwise provide any compensated patient care whatsoever.

☐ 8. I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance: (Must have approval from the Colorado Commissioner of Insurance. See note below).

☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

NOTE: The Commissioner of Insurance approves alternatives for financial responsibility. Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used. The address of the Commission Office is: 1560 Broadway, Suite 850, Denver, Colorado 80202: (303) 894-7499.

MAKE CHECKS PAYABLE TO: COLORADO BOARD OF MEDICAL EXAMINERS

☐ **INACTIVE LICENSE: FEE - $150.** I wish to renew my license via INACTIVE STATUS. (NOTE: this category is primarily intended for retired physicians and those practicing outside Colorado.) Malpractice insurance is not required for inactive license holders. **I understand that I may not practice medicine, including prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license. I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional $155.00. I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.**

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

Ruth K Weir [signature]	4/9/99	(303)440-3141	(303)541-0807
Signature of Physician	Date	Phone #	Fax ##

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee, and 3) the Physician Survey (optional) in the enclosed return envelope. Direct questions to: **(303) 894-7719 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver, CO 80202-5140**

COLORADO BOARD OF MEDICAL EXAMINERS
2001 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #	LICENSE #
Weinberg	Ruth	K	REDACTED	35265

PLEASE PRINT LEGILBY. KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

NOTE: The Colorado Medical Practice Act mandates that all licensed physicians wishing to renew their Colorado medical licenses must complete this questionnaire and renewal application

INSTRUCTIONS: Print or type your name, social security number and license number in the boxes above Answer each question below, and provide the information and documentation requested for each "yes" response

RESPONDING "YES" TO ANY OF THESE QUESTIONS WILL NOT DELAY RENEWAL OF YOUR LICENSE.
AN INCOMPLETE OR INACCURATE FORM, HOWEVER, WILL RESULT IN DELAY OF YOUR RENEWAL COMPLETE BOTH SIDES OF THIS FORM.

A) Since you last renewed your Colorado medical license, have you

1 had any adverse action taken against you by any licensing agency in another state or country, any peer review body, health care facility, professional or medical society or association, governmental agency, law enforcement agency, or court of law?
☐ YES ☑ NO

If "YES", provide a detailed summary of the events, which led to the adverse action Include the name and address of the entity that took the action, the date of the action, correspondence from the entity regarding the matter, and whether action is still pending

2 surrendered a license or other authorization to practice medicine in another state or jurisdiction, or surrendered membership on any medical staff, medical or professional association or society while under investigation by any of these authorities or bodies?
☐ YES ☑ NO

If "YES", provide a detailed summary of the events, which led to the adverse action Include the name and address of the entity that took the action, the date of the action, correspondence from the entity regarding the matter, and whether action is still pending

3 had paid on your behalf any final judgment, settlement or arbitration award for medical malpractice? NOTE Include any payments you have made personally ☐ YES ☑ NO

If "YES", provide a detailed clinical summary of your care and treatment of the patient Include the name of the patient, the amount and date of settlement, and a current copy of your complete National Practitioner Data Bank report (The Board may request patient records in the matter at a later date)

4 been denied liability insurance in Colorado or had your insurance coverage in Colorado terminated by action of the insurance carrier? ☐ YES ☑ NO

If "YES", provide a copy of the notification from the insurance carrier and a summary of the events, which led to the denial If you do not have a copy of the notification, contact the insurance carrier to obtain one

5 had any felony or misdemeanor charges of any kind brought against you? Had any traffic citations involving drugs or alcohol, brought against you? Regardless of the case disposition, you **must** answer yes if you have been charged
☐ YES ☑ NO

If "YES", provide a detailed summary of the events, which led to the charges or citation Include with your summary a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction

6 illegally or excessively used any controlled substance, habit-forming drug, prescription medication, or alcohol? You may answer "NO" if the behavior is already known to the Colorado Physician Health Program (CPHP) REDACTED

If "YES", provide a detailed summary of the condition or event Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers

7 engaged in any behavior or suffered any mental or physical health condition that might affect your ability to practice medicine with skill and safety to patients? You may answer "NO" if the behavior is already known to the Colorado Physician Health Program (CPHP) REDACTED

If "YES", provide a detailed summary of the condition or event Include the date of onset, date(s) and summary of treatment(s) received, the current status of your condition, and the name and address of all treatment providers

B) Since you last renewed your Colorado medical license, have either of the following been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? You are obligated to answer "YES" to the items below if any of these actions are currently pending NOTE You must answer "YES" if you have withdrawn or failed to proceed with an application for any of these items

1 Medical staff membership or clinical privileges at any hospital or healthcare facility? ☐ YES ☑ NO

If "YES", provide a detailed summary of the conduct/allegations upon which action was taken Include the notification to you from the hospital(s) or facility(s) If you do not have the notification(s), contact the hospital(s) or facility(s) to obtain one

2 DEA registration? ☐ YES ☑ NO

If "YES", provide a detailed summary of the conduct/allegation upon which action was taken Include the notification from DEA If you do not have a copy of the notification, contact DEA to obtain a copy

HAVE YOU PREVIOUSLY REPORTED ANY OF THE ABOVE MATTERS TO THE BOARD? ☐ YES ☑ NO

IF YES, PROVIDE DOCUMENTATION IN SUPPORT OF YOUR RESPONSE. IF APPLICABLE, PROVIDE A COPY OF THE FINAL DISPOSITION FROM THE BOARD.

2001 LICENSE RENEWAL QUESTIONNAIRE AND INSURANCE VERIFICATION FORM

As part of your application to renew your license to practice medicine in Colorado you must indicate how you are *complying with the requirement to maintain financial responsibility* Please be advised, you CANNOT use this renewal form to change your status from FROM INACTIVE TO ACTIVE You must complete a reactivation application to reactivate your license Please call the Board Office at (303) 894-7690 to request a reactivation application This is a process separate and independent from the renewal process

☒ <u>ACTIVE LICENSE</u> FEE - $315 I wish to renew my license in ACTIVE STATUS I meet (or claim exemption from) the financial responsibility standards as indicated below You **must check at least one.**

- ☒ I maintain commercial professional liability insurance with a carrier authorized to do business in Colorado, in minimum indemnity amounts of at least $500,000 per incident and $1,500,000 annual aggregate per year

  ☒ COPIC ☐ Doctors Company ☐ St Paul ☐ Other (Specify) ________

  NOTE Please supply your insurance policy number REDACTED

- ☐ I am a federal civilian or military physician whose practice is limited solely to that required by my federal/military agency
- ☐ I am a physician who is not engaged in the practice of medicine
- ☐ *I am a physician who is covered by individual commercial professional liability coverage* (or an alternative which complies with Section 13-64-301(1)(c), (d) or (e)) maintained by an employer/contracting agency in the amounts set forth above
- ☐ I am a physician who provides uncompensated health care to patients, or who does not otherwise engage in any compensated patient care in Colorado
- ☐ I have met the financial responsibility standards by the following alternative method, acceptable to the Colorado Division of Insurance (Must have approval from the Colorado Commissioner of Insurance See note below)

  ☐ Surety Bond ☐ Cash Deposit or equivalent ☐ Other Acceptable Security

NOTE The Commissioner of Insurance approves alternatives for financial responsibility Certification from the Insurance Commission MUST BE ATTACHED if an alternative method is used The address of the Commission Office is: 1560 Broadway, Suite 850, Denver, Colorado 80202: (303) 894-7499

☐ INACTIVE LICENSE FEE - $160 I wish to renew my license in INACTIVE STATUS Malpractice insurance is not required for inactive license holders **I understand that I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an active license.** I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee I also understand that if I have not actively practiced medicine for 2 years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations

MAKE CHECKS PAYABLE TO: COLORADO BOARD OF MEDICAL EXAMINERS

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

Ruth K Wein[signature] 4/9/01

Signature of Physician **Date**

Ruth K. Weinberg 35265

Print name of physician (printed name and license number must be legible to process this form) **License #**

After completing this form, please return it with 1) the enclosed computer renewal form, 2) the renewal fee and 3) the Physician Survey (optional) in the enclosed return envelope Direct questions to (303) 894-7690 Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver CO 80202-5140

Renewal - DR.0035265

Name	Ruth Kibbee Weinberg
Credential	DR 0035265

Fee Detail

Renewal Fee	$2 00
Renewal Fee	$334.00
Renewal Fee	$3 00
Renewal Fee	$18.00
Renewal Fee	$144 00
	$501.00

DR Renewal HPPP

Healthcare Professions Profiling Program ACTIVE status only:

All ACTIVE status licensees must maintain a Healthcare Professions Profile with current information. Please note that licensees are required to update their Healthcare Professions Profile within 30 days of changes or any reportable events. To access your HPPP account, please go to the HPPP Database by **CLICKING HERE** and enter your Login ID and Password for the HPPP system - these may be different from your User ID and password for this account in the Online Services system. Remember, it is your responsibility to maintain the accuracy of your Healthcare Profile within 30 days of any change. Failure to timely update your database may subject your license to disciplinary action.

DR Renewal Questionnaire

PART I: MANDATORY RENEWAL QUESTIONNAIRE

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

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

1. Have you been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any health care facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law, whether involuntary or in lieu of investigation?
No

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

If you answer YES to question number 2, you must provide a detailed summary of the events which led to the charges or citation. Include a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.
No

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

If you answer YES to question number 3, you must provide a copy of the notification from the insurance carrier and a summary of the events which led to the action by the carrier If you do not have a copy of the notification, contact the insurance carrier to obtain one
No

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

If you answer YES to question number 4, you must provide a detailed summary of the events which led to the charges or citation. Include a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.
No

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

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

If you answer YES to questions 5, you must provide a detailed summary to the Board of the conduct/allegation upon which action was taken.
No

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

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

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

No

SECTION B IN THE LAST TWO YEARS:

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

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

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

R

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

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

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

R

PART 2: MANDATORY ATTESTATION

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

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

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

Please select only 1 item below.

A I maintain commercial professional liability insurance with COPIC, in minimum indemnity amounts of at least $1,000,000 per incident and $3,000,000 annual aggregate per year

KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

Review

Renewal - DR.0035265

Name	Ruth Kibbee Weinberg
Credential	DR.0035265

Fee Details

Renewal Fee	$2.00
Renewal Fee	$238.00
Renewal Fee	$18.00
Renewal Fee	$162.00
	$420.00

Affidavit of Eligibility - Screening Present

AFFIDAVIT OF ELIGIBILITY

1. Do you currently reside in and are you physically present in the United States?
   Yes

Affidavit of Eligibility - Screening Doc Change

AFFIDAVIT OF ELIGIBILITY

2. Are you a United States Citizen and the State or Federally issued document, in which you proved your legal status in the United States is still valid **and** has not expired since you last completed an Affidavit of Elig bility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

-OR-

Are you Not a United States Citizen, but are lawfully present in the United States **and** your legal status within the United States has not changed **and** the legal documents used to prove lawful presence have not changed since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

If you need to update your lawful presence information, select no and you will be prompted to complete a new Affidavit of Eligibility. Otherwise, if your information has not changed, select yes to move forward.
   Yes

Affidavit of Eligibility

AFFIDAVIT OF ELIGIBILITY

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

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

3. Please enter your Full Legal Name

Affidavit of Eligibility - Section A

Section A: LAWFUL PRESENCE in the United States

4. Select one of the following Lawful Presence types below and click "Next" when done:

Affidavit of Eligibility - Section B.1

Section B: SECURE AND VERIFIABLE DOCUMENTS

5. Do you have a State or Federal government issued identification?

These include:

- Driver's License or Permit
- Government Issued ID Card
- Valid U.S. Military Common Access Card
- Colorado Department of Corrections Inmate ID
- Tribal ID Card
- U.S. Passport
- Certificate of Naturalization
- Certificate of (U.S.) Citizenship
- Valid Temporary Resident card
- Valid I-94 issued by Canadian government
- Valid I-94 with refugee/asylum stamp

Affidavit of Eligibility - Section B.1 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

6. Select one of the following Government Issued Identification:

7. Enter the name of State or Federal Agency that issued the identification:

8. Enter your full name as shown on the driver's license or State/Federal issued identification:

9. Enter the State/Federal government issued license/ID number:

10. Enter the expiration date of the license/ID:

11. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.2

Section B: SECURE AND VERIFIABLE DOCUMENTS

12. Do you have a Valid I-766 (Employment Identification Card)?

Affidavit of Eligibility - Section B.2 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

13. Enter the issuing Federal Agency:

14. Enter the name as listed on the card:

15. Enter the Alien number (A#):

16. Enter the card number:

17. Enter the Valid From Date:

18. Enter the Expiration Date:

19. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.3

Section B: SECURE AND VERIFIABLE DOCUMENTS

20. Do you have a Valid I-551 (Resident Alien or Permanent Resident Card)?

Affidavit of Eligibility - Section B.3 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

21. Enter the issuing Federal Agency:

22. Enter the name as listed on the card:

23. Enter the Alien Number (A#):

24. Enter the country of birth:

25. Enter the card expiration date:

26. Enter the Residence Since date:

27. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.4

28. Do you have a Valid Foreign Passport with an unexpired Visa with proper classification for work authorization, and an unexpired I-94?

Affidavit of Eligibility - Section B.4 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

29. Enter the issuing foreign country:

30. Enter the Passport Number:

31. Enter the Visa Number:

32. Enter the Visa Class (Examples: J-1, P-1 H-1B, etc.):

33. Enter the Date of Entry:

34. Enter the Until Date:

35. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Affidavit of Eligibility - Section B.5

Section B: SECURE AND VERIFIABLE DOCUMENTS

36. Do you have a valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa?

Affidavit of Eligibility - Section B.5 if Yes

Section B: SECURE AND VERIFIABLE DOCUMENTS

37. Enter the issuing foreign country:

38. Enter the Passport Number:

39. I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to

verification

Affidavit of Eligibility - Section C

Section C: Attestation

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.
- I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in section 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified on the previous pages and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the information on the previous pages must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

40. By entering your full legal name below you attest that you have read and understand the above information.

41 Please enter today's date below

DR Renewal Attestation

The below attestations apply to your license's CURRENT status. You may not change your status through online renewal. To change your status, please contact the licensing office at dora_registrations@state.co.us or 303-894-7800.

By renewing my license in INACTIVE status, I attest that:

- I understand malpractice insurance is not required for Inactive license holders; however, I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an Active license I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee I also understand that if I have not actively practiced medicine for two (2) years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations

By renewing my license in ACTIVE status, I attest that:

- REDACTED

AND

REDACTED REDACTED REDACTED REDACTED REDACTED

OR

REDACTED

- In the last 2 years, no adverse action has been taken against my license by another licensing agency, a peer review body, a health care institution, a residency or postgraduate training program, a professional or medical society or association, a governmental agency, a law enforcement agency, or a court for acts or conduct which, would constitute grounds for disciplinary or adverse actions pursuant to the Medical Practice Act or its attendant rules. For the purpose of this attestation, an adverse action by a law enforcement agency includes: 1) all felony charges; 2) all misdemeanor charges; or, 3) traffic charges/citations involving alcohol, controlled substances, or any other habit-forming drug.

OR

I have reported, or will report within 30 days, any adverse action to the Board in accordance with the requirements of the Medical Practice Act.

- In the last 2 years, I have not been denied medical liability insurance and no liability insurance coverage has been limited, restricted, or terminated by action of the insurance carrier in this or any other state.

OR

I have reported, or will report within 30 days, any denial or limitation of medical liability coverage to the Board

- I have established and will continuously maintain professional liability insurance as required by §13 64 301, C R S

Click Next to proceed.

GLOBAL HPPP Renewal Attestation

Pursuant to section 24-34-110, C.R.S., all Active and Retired status licensees must maintain a current Healthcare Professions Profile. Reportable events and/or changes to information must be made within 30 days. For more information about this Program and to update your profile, visit www.dora.colorado.gov/professions/hppp.

By renewing your Active or Retired license, you attest to the following:

I have updated my Healthcare Professions Profile to current date and/or I will make any updates within 30 days of any reportable event or change, and subsequent updates will be made within 30 days. This requirement is in addition to any requirement by a profession's practice act. Examples of reportable events or changes that must be updated on a profile include, but are not limited to, location of practice, public actions issued by any jurisdiction, felonies and crimes of moral turpitude, malpractice settlements/judgments, etc. To update a Healthcare Professions Profile, or for more information on the Healthcare Professions Profile Program (HPPP) and its requirements, visit www.dora.colorado.gov/professions/hppp or call 303-894-5942.

If your status is Inactive you are not required to maintain a Healthcare Professions Profile, click next to proceed

You may NOT change your status through online renewal. For information regarding a status change, please contact the renewal desk at 303-894-7800 or dora_dpo_renewalline@state.co.us.

Click next to proceed.

Review

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

Renewal - DR.0035265

Name	Ruth Kibbee Weinberg
Credential	DR.0035265

Fee Details

DR - Legal Defense Fund	$2.00
DR - PDMP Fee	$24.00
DR - Portal Fee	$1.50
DR - Renewal Fee Active	$238.50
DR- Peer Fee	$162.00
	$428.00

Affidavit of Eligibility - Screening Present

AFFIDAVIT OF ELIGIBILITY

1. Do you currently reside in and are you physically present in the United States?
   Yes

Affidavit of Eligibility - Screening Doc Change

AFFIDAVIT OF ELIGIBILITY

2. Are you a United States Citizen and the State or Federally issued document, in which you proved your legal status in the United States is still valid **and** has not expired since you last completed an Affidavit of Elig bility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

-OR-

Are you Not a United States Citizen, but are lawfully present in the United States **and** your legal status within the United States has not changed **and** the legal documents used to prove lawful presence have not changed since you last completed an Affidavit of Eligibility? (This would have been either at your original licensure or your last renewal, whichever is more recent).

If you need to update your lawful presence information, select no and you will be prompted to complete a new Affidavit of Eligibility. Otherwise, if your information has not changed, select yes to move forward.
Yes

DR Renewal Attestation

The below attestations apply to your license's CURRENT status. You may not change your status through online renewal. To change your status, please contact the licensing office at dora_registrations@state.co.us or 303-894-7800.

By renewing my license in INACTIVE status, I attest that:

I understand malpractice insurance is not required for Inactive license holders; however, I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an Active license. I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee. I also understand that if I have not actively practiced medicine for two (2) years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.

By renewing my license in ACTIVE status, I attest that:

- REDACTED

  OR

  REDACTED

- In the last 2 years, no adverse action has been taken against my license by another licensing agency, a peer review body, a health care institution, a residency or postgraduate training program, a professional or medical society or association, a governmental agency, a law enforcement agency, or a court for acts or conduct which, would constitute grounds for disciplinary or adverse actions pursuant to the Medical Practice Act or its attendant rules. For the purpose of this attestation, an adverse action by a law enforcement agency includes: 1) all felony charges; 2) all misdemeanor charges; or, 3) traffic charges/citations involving alcohol, controlled substances, or any other habit-forming drug.

OR

I have reported, or will report within 30 days, any adverse action to the Board in accordance with the requirements of the Medical Practice Act.

- REDACTED

OR

REDACTED

- In the last 2 years, I have not been denied medical liability insurance and no liability insurance coverage has been limited, restricted, or terminated by action of the insurance carrier in this or any other state.

OR

I have reported, or will report within 30 days, any denial or limitation of medical liability coverage to the Board.

- I have established and will continuously maintain professional liability insurance as required by §13-64-301, C.R.S.

Click Next to proceed.

HPPP - DR Introduction

Healthcare Professions Profile

Please be aware that this profile is only for your Physician license. Do not provide information for other license types you hold on this profile. You will be required to complete a profile for every license you hold that is included in the profiling requirement.

All information provided in this profile must be updated within 30 days of any change of information unless your profession's statute says otherwise, or unless the question specifies otherwise.

HPPP GLOBAL - Location of Practice

Location of Practice

49. Are you currently practicing in the healthcare profession associated with this profile?

Yes

HPPP GLOBAL - Location of Practice If Yes

Location of Practice

50. Practice Locations:

Address	City	State	Zip Code	Phone Number
2855 Valmont Rd	Boulder	Colorado	80301	(303) 442-5160

HPPP - MEDICAL Education and Training

Education and Training

51. School or Education Level:

University of Washington School of Medicine

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

1992

HPPP GLOBAL - Other Licenses

Other Licenses

53 Have you ever held, or do you currently hold any other licenses in this profession from any other state, country or province?
Yes

HPPP GLOBAL - Other Licenses if Yes

Other Licenses

54. Other Licenses:

State	License Status	Year Originally Issued
Washington	Expired	1992

HPPP GLOBAL - Board Certifications

Board Certifications

55 Do you hold any current Board Certifications?
Yes

HPPP - MEDICAL Board Certifications if Yes

Board Certifications

56. Board Certifications:

Certification
Obstetrics and Gynecology

HPPP GLOBAL - Practice Specialties

Practice Specialties

57 Do you have a practice specialty in which you are appropriately trained and actively practicing?
Yes

HPPP - MEDICAL Practice Specialties if Yes

Practice Specialties

58. Practice Specialties:

Specialty
Obstetrics and Gynecology

HPPP GLOBAL - CO Hospital Affiliations

Colorado Hospital Affiliations

59. Do you have a current affiliation or clinical privileges with any Colorado Hospital?
Yes

HPPP GLOBAL - CO Hospital Affiliations if Yes

Colorado Hospital Affiliations

60. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
Avista Adventist Hospital	Other	Boulder

HPPP GLOBAL - Other Hospital Affiliations

Other Health Care Facilities and Out of State Hospital Affiliations

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

HPPP GLOBAL - Business Ownership

Business Ownership

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

HPPP GLOBAL - Employer

Employer

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

HPPP GLOBAL - Employer if Yes

Employer

66. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
Boulder Valley Women's Health Center	2855 Valmont Rd	Boulder	Colorado	80301	(303) 442-5160

HPPP GLOBAL - Employment Contracts

Employment Contracts

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

HPPP GLOBAL - Disciplinary Actions

Disciplinary Actions

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

HPPP GLOBAL - Restrictions and Suspensions

Restrictions and Suspensions

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

HPPP GLOBAL - Healthcare Facility Actions

Healthcare Facility Actions

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

HPPP GLOBAL Termination of Employment

Termination of Employment

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

HPPP GLOBAL - DEA Registration

DEA Registration Surrender

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

HPPP GLOBAL - Convictions

Convictions

80. Since you were issued a license to practice your profession in any state or country, have you had any final criminal conviction(s) or plea arrangement(s) resulting from the commission or alleged commission of a felony or crime of moral turpitude in any jurisdiction?
No

HPPP GLOBAL - Malpractice Claims

Malpractice Claims

82. Since September 1, 1990, have you had any final judgment, entered into a settlement, or paid an arbitration award for malpractice?
No

HPPP GLOBAL Malpractice Carrier Refu al

Malpractice Carrier Refusal

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

No

HPPP GLOBAL   Optional Narrative

Optional Narrative

86. Optional Narrative:

HPPP GLOBAL - Attestation

Attestation

By submitting this Healthcare Professions Profile to the Division of Professions and Occupations you are attesting that

- You are the person identified in this profile; or
- You are authorized to submit information on behalf of the person identified in this profile; and
- The information contained herein is true and correct to the best of my knowledge.

87. Submission Date:
03/17/2017

Review

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

Renewal - DR.0035265

Name	Ruth Kibbee Weinberg
Credential	DR.0035265

Fee Details

DR - Legal Defense Fund	$2.00
DR - PDMP Fee	$24.00
DR - Portal Fee	$1.50
DR - Renewal Fee Active	$218.50
DR- Peer Fee	$140.00
	$386.00

DR Renewal Attestation

The below attestations apply to your license's CURRENT status. You CANNOT change your status through online renewal. To change your status, please contact the licensing office at dora_registrations@state.co.us or 303-894-7800. DR have Active and Inactive options, CDRH has Active only

By renewing my license in INACTIVE status, I attest that:

I understand malpractice insurance is not required for Inactive license holders; however, I may not practice medicine, including but not limited to prescribing medications, in Colorado unless and until I comply with the insurance requirements and the Board issues me an Active license. I understand that should I desire to reactivate my Colorado medical license at some future time, I will be required to complete the reactivation application and pay an additional fee. I also understand that if I have not actively practiced medicine for two (2) years or more and then wish to reactivate my Colorado medical license, I will be required to demonstrate continued competence pursuant to Board rules and regulations.

By renewing my license in ACTIVE status, I attest that I have NOT engaged in any conduct or exhibited any behaviors that resulted in the following following OR that I have reported, or will report this information within 30 days to the Colorado Medical Board at dora_medicalboard@state.co.us or 303-894-7690.:

- An arrest, discipline, sanction or warning
- Loss or suspension of any license
- Termination or suspension of any license
- Endangering the safety of others
- A breach of fiduciary obligations
- A violation of workplace or academic conduct rules
- An impairment of your ability to practice in a safe, competent, ethical and professional manner
- Abusing or excessively using any habit forming drug, including alcohol, or any illegal or controlled substance resulting in any discipline for misconduct, failure to meet professional responsibilities, or affecting your ability to practice safely and competently
- Claiming the illegal use of a substance as a defense, in mitigation, or as an explanation for any conduct that impairs your ability to practice in a safe, competent, ethical, and professional manner

By renewing my license in ACTIVE status, I attest that I have NOT had an adverse action or administrative/judicial proceeding and I do not have a pending inquiry or investigation within the last two years by the following OR that I have reported, or will report this information within 30 days to the Colorado Medical Board at dora_medicalboard@state.co.us or 303-894-7690:

- A licensing authority - other than the Colorado Medical Board
- A government agency
- A court
- An employer
- An educational institution
- A professional organization
- In connection with an employment disciplinary or termination procedure

By renewing my license in ACTIVE status, I attest that: I have established and will continuously maintain professional liability insurance as required by 13-64-301, C.R.S.

All statuses click Next to proceed.

PDMP Renewal Attestation

By renewing your license in Active status, you agree with the following statement:

I attest that IF I maintain a current United States Drug Enforcement Agency (DEA) registration, I have registered an individual user account with Colorado's Prescription Drug Monitoring Program (PDMP) at https://colorado.pmpaware.net.

(If you have questions about registering or to check if you have registered, please email the PDMP Help Desk at pdmpinqr@state.co.us for assistance.)

Click Next to proceed.

AoE Renewal Update

Affidavit of Eligibility | Renewal Update of Information

1. Since you were originally licensed or since your last renewal (whichever was more recent) has the documentation you provided proving your legal status in the United States changed?

- If nothing has changed in your legal status or documentation, select "No"
- If your status has changed, or you need to update your documentation, select "Yes" to update your information

No

AoE Attestation

Affidavit of Eligibility | Section C: Attestation

By submitting this Affidavit of Eligibility (AoE) you are attesting that you have read and understand the statements below:

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document.
- I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in section 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified on the previous pages and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the information on the previous pages must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

96. Please enter today's date below:
04/02/2019

Healthcare Profile - Physician Introduction

Healthcare Professions Profile | Introduction

Please be aware that this profile is only for your PHYSICIAN license. Do not provide information for other license types you hold on this profile. You will be required to complete a profile for every license you hold that is included in the profiling requirement.

All information provided in this profile must be updated within 30 days of any change of information unless your profession's statute says otherwise, or unless the question specifies otherwise.

Healthcare Profile - Location of Practice

Healthcare Professions Profile | Location of Practice

97. Are you currently practicing in the healthcare profession associated with this profile?

Yes

Healthcare Profile - Location of Practice if Yes (WF)

Healthcare Professions Profile | Location of Practice

98. Practice Locations:

Address	City	State	Zip Code	Phone Number
2855 Valmont Rd	Boulder	Colorado	80301	3034425160

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

99. School or Education Level:
University of Washington School of Medicine

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

1992

Healthcare Profile - Other Licenses

Healthcare Professions Profile | Other Licenses

101. Have you ever held, or do you currently hold any other licenses in this profession from any other state, country or province?
Yes

Healthcare Profile Other Licen e if Ye

Healthcare Professions Profile | Other Licenses

102. Other Licenses:

State	License Status	Year Originally Issued
Washington	Expired	1992

Healthcare Profile - Board Certifications

Healthcare Professions Profile | Board Certifications

103. Do you hold any current Board Certifications?
Yes

Healthcare Profile Medical Board Certification if Ye

Healthcare Professions Profile | Board Certifications

104. Board Certifications:

Certification
Obstetrics and Gynecology

Healthcare Profile - Practice Specialties

Healthcare Professions Profile | Practice Specialties

105. Do you have a practice specialty in which you are appropriately trained and actively practicing?
Yes

Healthcare Profile Medical Practice Specialtie if Ye

Healthcare Professions Profile | Practice Specialties

106. Practice Specialties:

Specialty
Obstetrics and Gynecology

Healthcare Profile - Colorado Hospital Affiliations

Healthcare Professions Profile | Colorado Hospital Affiliations

107. Do you have a current affiliation or clinical privileges with any Colorado Hospital?
Yes

Healthcare Profile - Colorado Hospital Affiliations if Yes

Healthcare Professions Profile | Colorado Hospital Affiliations

108. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
Avista Adventist Hospital	Other	Boulder

Healthcare Profile - Other Facility and Out of State Hospital Affiliations

Healthcare Professions Profile | Other Facility and Out of State Hospital Affiliations

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

Healthcare Profile - Business Ownership

Healthcare Professions Profile | Business Ownership

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

Healthcare Profile - Employer

Healthcare Professions Profile | Employer

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

Healthcare Profile - Employer if Yes

Healthcare Professions Profile | Employer

114. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
Boulder Valley Women's Health Center	2855 Valmont Rd	Boulder	Colorado	80301	(303) 442-5160

Healthcare Profile - Employment Contracts

Healthcare Professions Profile | Employment Contracts

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

Healthcare Profile - Disciplinary Actions

Healthcare Professions Profile | Disciplinary Actions

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

Healthcare Profile Re triction and Su pen ion

Healthcare Professions Profile | Restrictions and Suspensions

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

Healthcare Profile - Healthcare Facility Actions

Healthcare Professions Profile | Healthcare Facility Actions

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

Healthcare Profile - Termination of Employment

Healthcare Professions Profile | Termination of Employment

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

Healthcare Profile - DEA Registration

Healthcare Professions Profile | DEA Registration

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

Healthcare Profile Conviction

Healthcare Professions Profile | Convictions

128. Since you were issued a license to practice your profession in any state or country, have you had any final criminal conviction(s) or plea arrangement(s) resulting from the commission or alleged commission of a felony or crime of moral turpitude in any jurisdiction?
No

Healthcare Profile - Malpractice Claims

Healthcare Professions Profile | Malpractice Claims

130 Since September 1, 1990, have you had any final judgment, entered into a settlement, or paid an arbitration award for malpractice?
No

Healthcare Profile - Malpractice Carrier Refusal

Healthcare Professions Profile | Malpractice Carrier Refusal

132 Have you been denied liability insurance, or has your liability insurance coverage been limited, restricted or terminated by the insurance carrier?
No

Healthcare Profile - Optional Narrative

Healthcare Professions Profile | Optional Narrative

134. Optional Narrative:

Healthcare Profile - Attestation

Healthcare Professions Profile | Attestation

By submitting this Healthcare Professions Profile to the Division of Professions and Occupations you are attesting that:

- I am the person identified in this profile; or
- You are authorized to submit information on behalf of the person identified in this profile; and
- The information contained herein is true and correct to the best of my knowledge.

135 Submission Date
04/02/2019

Review

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