University of Colorado Anschutz Medical Campus

School of Medicine
Office of Graduate Medical Education

13001 E. 17th Pl, C293, Aurora, CO 80045
Phone: 303-724-6031; Fax: 303-724-6034

CONFIRMATION OF MALPRACTICE COVERAGE

Date: February 1, 2017
*Resident: Lindy Vanlandingham, MD
Program start date: 06/23/2013
Program end date: Until Completion of Program

The University of Colorado provides medical malpractice coverage for its employees, residents, students, and volunteers through a combination of self-insurance and commercial insurance. This coverage is subject to the terms of the University of Colorado Self-Insurance and Risk Management Trust Coverage Document. Coverage extends to injuries arising from acts or omissions occurring during the performance of the covered person's duties and within the scope of the covered person's duties and within the scope of the covered person's employment or training, unless the act or omission was willful and wanton.

The Trust's coverage extends to employees, residents, students, and volunteers defined in the Trust Coverage Document and in accordance with the Colorado Governmental Immunity Act (C. R. S. 24-10-101 et. seq.). These employees, residents, students, and volunteers are considered to be "public employees" under the Colorado Governmental Immunity Act and their liability is limited by the Act as follows:

(a) for any injury to one person in any single occurrence, which occurred prior to July 1, 2013, the sum of $150,000; for an injury which occurred on or after July 1, 2013, the sum of $350,000;

(b) for any injury to two or more persons in any single occurrence, which occurred prior to July 1, 2013, the sum of $600,000; except in such instance, no person may recover in excess of $150,000; for an injury which occurred on or after July 1, 2013, the sum of $990,000, except in such instance, no person may recover in excess of $350,000.

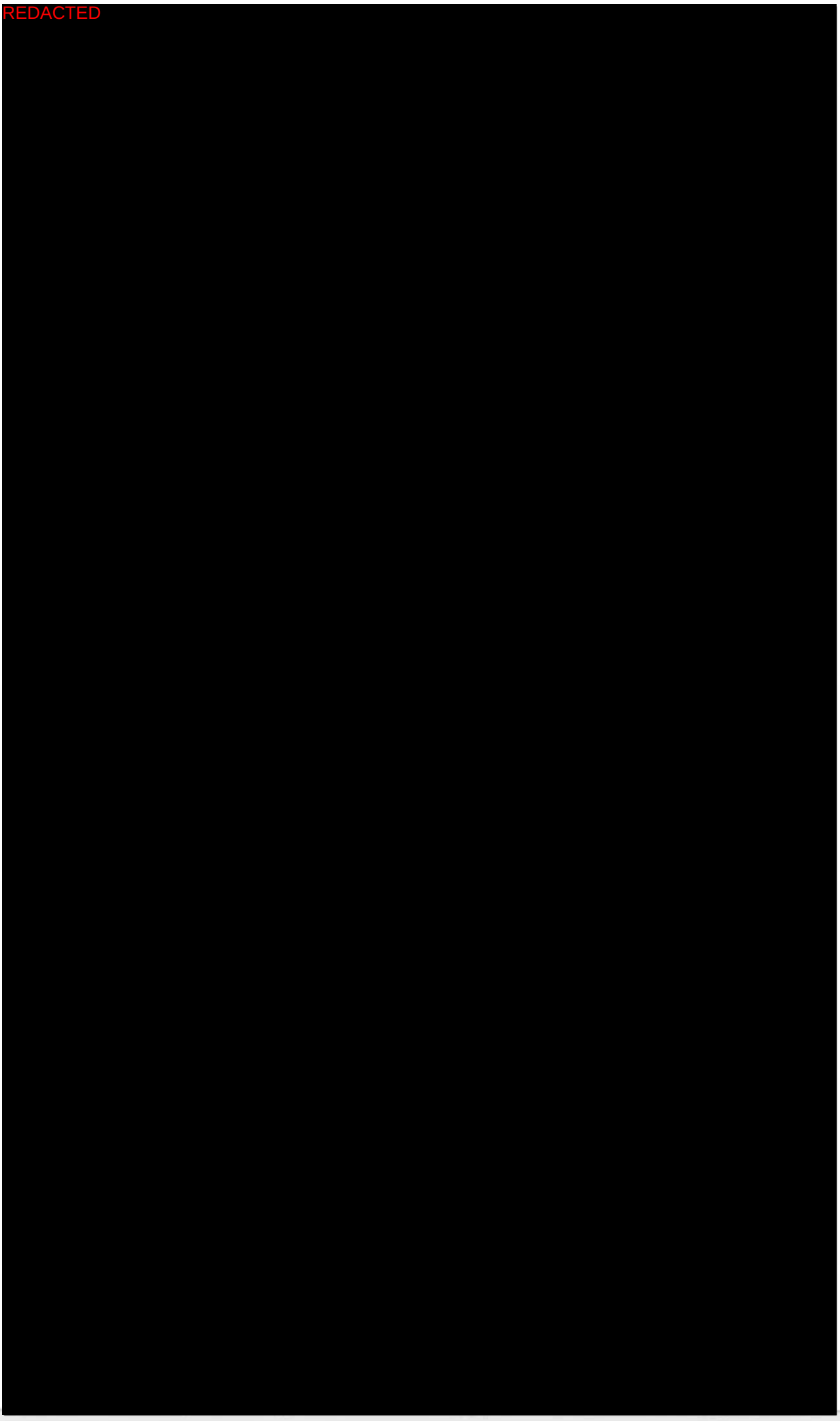
For claims subject to the protection of the Colorado Governmental Immunity Act, if a court of competent jurisdiction rules as final judgment that the limitations of the Act are not applicable to the University, the University of Colorado Hospital, a particular public employee, faculty member, or student, then the Trust provides **secondary** coverage through a commercial policy which has limits of at least $6,000,000 per occurrence and $6,000,000 in aggregate. Both the coverage under the Colorado Governmental Immunity Act as well as the secondary coverage provided be the Trust which are outlined above apply to acts that occurred within the course and scope of the employees work for the university or which occurred during the time that the resident or student was enrolled in the program.

All inquiries regarding the coverage provided or claims history for the individual named above should be directed to the Office of Professional Risk Management, Mail Stop F407, 13001 E. 17th Place, Aurora, CO 80045.

Carol M. Rumack, M.D./Designee
Associate Dean
Graduate Medical Education

* ACGME defines "resident' as intern, resident, and fellow.

REDACTED



Colorado Department of Regulatory Agencies
Division of Professions and Occupations
1560 Broadway, Suite 1350
Denver, CO 80202

Licensee/Applicant Full Legal Name

Last	First	Middle	Suffix
VANLANDINGHAM	LINDY	ANN	

Colorado Professional or Occupational License/Certification/Registration Number: TL 0004714
(if already licensed)

Professional or Occupational License/Certification/Registration type applying for: PHYSICIAN

AFFIDAVIT OF ELIGIBILITY

Pursuant to H.B. 06S-1009, 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.*

Section A: LAWFUL PRESENCE in the United States

1. ☒ I am a U.S. citizen. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
2. ☐ I am not a U.S. citizen, but I am lawfully present in the U.S. and authorized by the Department of Homeland Security to be employed in the U.S. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
3. ☐ I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.)
   a. ☐ I am a U.S. citizen, not physically present or employed in the United States.
   b. ☐ I am a Foreign National, not physically present or employed in the United States.

Section B: SECURE AND VERIFIABLE DOCUMENTS
Select ONE document in this section if you checked 1 or 2 in Section A.

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
☐ Driver's license or permit				
☐ Government issued ID card				
☐ Valid U.S. military ID/common access card				
☐ Colorado Department of Corrections inmate ID				
☐ Tribal ID card				
☒ U.S. passport	DEPT OF STATE	LINDY ANN VANLANDINGHAM	REDACTED	15 MAY 2024
☐ Certificate of Naturalization				

Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
☐ Certificate of (U.S.) Citizenship				
☐ Valid Temporary Resident card				
☐ Valid I-94 issued by Canadian government				
☐ Valid I-94 with refugee/asylum stamp				

☐ Valid I-766 (Employment Authorization Card) — **Issuing federal agency:**

Name on card	Alien Number (A#)	Card Number	Valid from (mm/dd/yyyy)	Expires (mm/dd/yyyy)

☐ Valid I-551 (Resident Alien or Permanent Resident Card) — **Issuing federal agency:**

Name on card	Alien Number (A#)	Country of birth	Card expires (mm/dd/yyyy)	Resident since (mm/dd/yyyy)

☐ Valid foreign passport with an unexpired visa with proper classification for work authorization, and an unexpired I-94

Issuing foreign country	Passport Number	Visa Number	Visa Class (ex.: J-1, P-1, H-1B, etc.)	Date of entry (mm/dd/yyyy)	Until date (mm/dd/yyyy)

☐ Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa

Issuing foreign country:	Passport Number:

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 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified above 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 above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

LINDY ANN VANLANDINGHAM
Print Full Legal Name

Signature (Full Name)

12-20-2016
Date

Renewal - TL.0004714

Name	Lindy Ann Vanlandingham
Credential	TL.0004714

Fee Details

TL - Legal Defense Fund	$2.00
TL - Renewal Fee Active	$9.00
	$11.00

Affidavit of Eligibility - Screening Present

AFFIDAVIT OF ELIGIBILITY

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

Affidavit of Eligibility - Screening Doc Change

AFFIDAVIT OF ELIGIBILITY

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

-OR-

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

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

TL Renewal Attestation

By renewing my license, I attest that:

- REDACTED

  AND

  REDACTED

  OR

  REDACTED

- In the last 3 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 REDACTED

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.

HPPP - TL Introduction

Healthcare Professions Profile

Please be aware that this profile is only for your Physician Training 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

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

Yes

HPPP GLOBAL - Location of Practice If Yes

Location of Practice

43. Practice Locations:

Address	City	State	Zip Code	Phone Number
770 Bannock	Denver	Colorado	80204	(303) 602-9000
12605 E 16th Ave	Aurora	Colorado	80045	(720) 848-0000
4567 E 9th Ave	Denver	Colorado	80220	(303) 320-2121

HPPP - MEDICAL Education and Training

Education and Training

44. School or Education Level:
University of Colorado School of Medicine

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

2013

HPPP GLOBAL - Other Licenses

Other Licenses

46. Have you ever held, or do you currently hold any other licenses in this profession from any other state, country or province?
No

HPPP GLOBAL - Board Certifications

Board Certifications

48. Do you hold any current Board Certifications?
No

HPPP GLOBAL - Practice Specialties

Practice Specialties

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

HPPP - MEDICAL Practice Specialties if Yes

Practice Specialties

51. Practice Specialties:

Specialty
Obstetrics and Gynecology

HPPP GLOBAL - CO Hospital Affiliations

Colorado Hospital Affiliations

52. Do you have a current affiliation or clinical privileges with any Colorado Hospital?
No

HPPP GLOBAL - Other Hospital Affiliations

Other Health Care Facilities and Out of State Hospital Affiliations

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

HPPP GLOBAL - Business Ownership

Business Ownership

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

HPPP GLOBAL - Employer

Employer

58. 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

59. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
University of Colorado Hospital	12631 E. 17th Ave. B 198-6	Denver	Colorado	80045	(303) 724-2052

HPPP GLOBAL - Employment Contracts

Employment Contracts

60. Do you have a contract with any business whose mission relates to healthcare services or products where the value is greater than $5000 annually?
Yes

HPPP GLOBAL - Employment Contracts if Yes

Employment Contracts

61. Employment Contracts:

Entity Name	Length of Contract	Contract Position
University of Colorado Hospital	4 years	Employee

HPPP GLOBAL - Disciplinary Actions

Disciplinary Actions

62. 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

64. 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

66. 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

68. 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

70. Have you ever had to involuntarily surrender your United States Drug Enforcement Agency Administration Registration?

No

HPPP GLOBAL - Convictions

Convictions

73. 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

75. 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 Refusal

Malpractice Carrier Refusal

77. 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

79. 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.

80. Submission Date:
08/08/2016

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.

COLORADO MEDICAL BOARD
CLAIMS INFORMATION FORM

Applicant: Complete this form for each liability or malpractice claim identified in the application Screening Question regarding malpractice.

LINDY VANLANDINGHAM
Name of Physician — Business Telephone Number

9987 SPRING HILL LANE, HIGHLANDS RANCH, CO 80129
Address — City, State, ZIP

1. On a separate sheet of paper, type your full name and provide a clinical narrative regarding each malpractice case(s) / allegations. Include name of patient, age, sex, date of occurrence, and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description, which includes all of the facts requested above. Simply stating that the charges were dismissed is inadequate, more detail must be provided.

2. Indicate your position in case, i.e., intern, resident, primary doctor, etc. Eight Individual providers were named in this claim that alleges a delay in definitive treatment of a spontaneous abortion. I was not involved in the care that was the subject of this claim. Should you have any further questions please contact risk manager Jeffrey Mailey at 303 724 7475

3. Case was filed against: ☐ Individual doctor ☒ Group ☒ Hospital

   List names of other doctors and/or hospitals also named in the suit: _____

4. Plaintiff's Attorney and Telephone: _____

5. Is the claim pending? ☒ YES ☐ NO

6. Was there a judgment or settlement? ☐ YES ☐ NO

7. What was the amount and date of the judgment or settlement? _____

8. What amount was attributable to you, your insurance company, or your employer? _____

I certify that the information I have provided is correct to the best of my knowledge.

Signature — Date: 12·30·16

PAID
412.00
1518507

FEB 9'17/ 0087

DPO 976

Division of Professions and Occupations
Office of Licensing–Medical
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7800 / Fax (303) 894-7693
www.dora.colorado.gov/professions

Application for Original License
PHYSICIAN
Fee: $412
Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to State of Colorado.

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

PART 1—APPLICANT INFORMATION

Name: First:	Middle:	Last:	☒ MD ☐ DO
LINDY	ANN	VANLANDINGHAM	

Previous Name(s):

Social Security Number: REDACTED

E-mail Address: REDACTED
(This will be the primary communication method)

Mailing Address:
This is a ☒ *Home* ☐ *Business*

PO Box, Street: 9987 SPRING HILL LANE
City, State, Zip: HIGHLANDS RANCH, CO 80129

Daytime Telephone Number: (719) 338-0272

Date of Birth (mm/dd/yyyy): REDACTED

Place of Birth (city and state, or foreign country): DOVER, DE

Gender: ☐ *Male* ☒ *Female*

PART 2—EDUCATION/ TRAINING

List the name and address of the school where your medical degree was received:

Name of School	Location (address and ZIP)	Years Attended (from / to)	Year of Graduation
UNIVERSITY OF COLORADO DENVER SCHOOL OF MEDICINE	13001 E. 17th PL. AURORA, CO 80045	2009-2013	2013

▶ If this is an international medical school, please provide the country where the school is physically located: _____

***Social Security Number Disclosure:** Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in Title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's Social Security Number. Disclosure of your Social Security Number is mandatory for purposes of establishing, modifying, or enforcing child support under Sections 14-14-113 and 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by Section 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the National Practitioner Data Bank pursuant to 45 CFR Sections 60.1 et seq., and the Health Integrity and Protection Data Bank as required by 45 CFR Sections 61.1 *et seq.* Failure to provide your Social Security Number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your Social Security Number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your Social Security Number will not be released for any other purpose not provided for by law.

OFFICE USE ONLY **LICENSE NUMBER:** _____ **DATE ISSUED:** _____

REDACTED

APPLICANT NAME: LINDY VANLANDINGHAM

PART 2—EDUCATION / TRAINING (Continued)

Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs? ☒ YES ☐ NO

► If **YES**, provide information below:

Name of Facility	Specialty	Years Attended (from / to)
UNIVERSITY OF COLORADO	OB/GYN	2013 - 2017

What is your specialty or specialties? OBSTETRICS AND GYNECOLOGY

PART 3—EXAMINATION / CERTIFICATION

List name of licensing exam(s): ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam.

Exam	Location	Date	Result
USMLE STEP 1,	COLORADO	4-6-2011	REDACTED
USMLE STEP 2 CK,	COLORADO	9-20-2012	
USMLE STEP 2 CS,	CALIFORNIA	9-13-2012	
USMLE STEP 3	, COLORADO.	5-13-2014	

► If this is an international medical school, please provide the country where the school is physically located: _____

Are you Board certified by either the American Board of Medical Specialties or the American Osteopathic Association? ☐ YES ☒ NO

► If **YES**, list certification information: _____

PART 4—LICENSE INFORMATION

A. Have you ever been licensed to practice medicine in any state, territory, district, or country? (include temporary licenses and educational permits) ☒ YES ☐ NO

► If **YES**, provide a complete list of all medical licenses (if needed, attach an additional sheet in the same format):

Type of license	State/Country	License Number	Year license issued	Disciplinary action against license?	Is this license current/active?
TRAINING	COLORADO	TL.0004714	2013	☐ YES ☒ NO	☒ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

B. Have you ever applied for any type of Colorado health care license prior to this application? ☐ YES ☒ NO

► If **YES**, provide application types and license information if applicable:

Application type	License Number	Month and year license issued

APPLICANT NAME: LINDY VANLANDINGHAM

PART 5—MALPRACTICE INSURANCE CERTIFICATION

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

Exemption Claimed: _____

PART 6—SCREENING QUESTIONS

1. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic licensing board of any complaint, investigation, or inquiry which is currently pending? ☐ YES ☒ NO
   - ► If **YES,** give details below AND request official complaint and/or investigative report be sent directly to the Board from the licensing body, as well as personally submit a narrative regarding the complaint.

Agency	Date	Charge	Disposition

2. Has any healing arts license which you now hold or have ever held 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 healthcare 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? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question. ☐ YES ☒ NO
   - ► If **YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board, as well as a narrative regarding the action taken.

Agency	Date	Charge	Disposition

3. Have you ever entered into any agreement with any state, territory, district, country, U.S. government agency, and state medical/osteopathic board regarding your medical license? ☐ YES ☒ NO
   - ► If **YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason

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

Agency	Date	Reason for Denial

APPLICANT NAME: LINDY VANLANDINGHAM

PART 6—SCREENING QUESTIONS (Continued)

5. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in any other state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. ☐ YES ☒ NO

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

Agency	Date	Reason

6. Have either your medical staff membership or clinical privileges at any hospital or healthcare facility or your DEA registration been voluntarily or involuntarily reduced, limited, placed on probation, not renewed or relinquished or have either been denied, revoked or suspended? You must answer YES if any of these actions are currently pending. You must answer YES if you have withdrawn or failed to proceed with an application for these items. ☐ YES ☒ NO

   ► If **YES,** summarize below AND request hospital or DEA to submit a report directly to the Board regarding the action. Also submit your narrative regarding the action taken.

Name of Facility	Date	Reason for Action

7. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law? Note: It is unnecessary to report traffic offenses that do not involve alcohol or drugs. ☐ YES ☒ NO

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

Date	Court	Violation	Penalty or Disposition

8. Do you now abuse or excessively use, or have you in the last five 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? REDACTED

9. In the last five 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 including but not limited to bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder? REDACTED

You may answer NO to Question 8 or 9 if the behavior or condition is already known to the Colorado Physician Health Program (CPHP). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment, and/or monitoring.

If you answer YES to Question 8 or 9, submit detailed information to the Board that will allow the Board to assess your ability to practice safely, competently, and without impairment to your professional judgment, skill, or knowledge. In addition to that information, you are required to provide copies of any related records, reports, evaluations, police reports, probation reports, and court records directly to the Board.

APPLICANT NAME: LINDY VANLANDINGHAM

PART 6—SCREENING QUESTIONS (Continued)

Please be advised that an affirmative response to Question 8 or 9 *may result in* a request from the Board for evaluation by the Colorado Physician Health Program (CPHP). The CPHP evaluation process could potentially delay consideration of an application. Therefore, the Board is providing advance notice of this possibility so that applicants may contact CPHP to schedule an evaluation at the beginning of the application process. By doing so, the application for licensure should not be unduly delayed. An applicant is not required to contact CPHP in advance of Board consideration of the application. The applicant may choose to wait for a specific decision by the Board that a CPHP evaluation is necessary. This information is being provided to put applicants on notice with respect to this potential requirement and afford the applicant the opportunity to expedite the process if he or she so desires. (Colorado Physicians Health Program – CPHP, 899 Logan Street, #410, Denver, CO 80203; (303) 860-0122.)

10. Within the last five years, has any final judgment, settlement or arbitration award for medical malpractice been paid on your behalf or has any claim been filed which is still pending? ☒ YES ☐ NO
    - ► If **YES**, summarize below AND submit to the Board a completed malpractice Claims Information Form (attached) and a clinical narrative regarding your involvement in the case.

Date	Name and Address of Insurance Company	Reason for Action
MAY 2015	HCD SELF INSURED TRUST	NOTICE OF CLAIM

11. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been canceled or rated at a higher premium due to past claims experience? ☐ YES ☒ NO
    - ► If **YES**, submit to the Board an explanation regarding the cancellation or increase in premiums of the insurance and verification directly from the insurance company to the Board.

PART 7—MILITARY

Are you a Member of the U.S. military? ☐ YES ☒ NO

- ► If **YES**, provide information below:

Branch:	Duty Station:

PART 8—SECURITY OF PATIENT MEDICAL RECORDS

☑ By checking this box, I attest that I have developed a written plan to ensure the security of patient medical records in compliance with § 12-36-140, C.R.S.

ATTESTATION

I 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), which includes state medical licensing boards and the Federation of State Medical Boards, to release to the licensing Board any information, files or records requested by the Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine during the processing of this application and the time that I am a licensee of this Board.

I state under penalty of perjury in the second degree, as defined in § 18-8-503, C.R.S., that the information contained in this application is true and correct to the best of my knowledge. In accordance with § 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law and may constitute violation of the practice act.

Signature of Applicant _____ Date 12/30/16

Scanned by CamScanner

Colorado Division of Professions and Occupations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303) 894-7800 / Fax: (303) 894-7693
www.dora.colorado.gov/professions

REPORT OF PRACTICE HISTORY

(See instructions on following page)

	Dates of Practice From mm/yyyy	Dates of Practice To mm/yyyy	Facility Name	Address (Street & Number, City, State, ZIP)	Reference (Name and Title)	Nature of Practice
1	6/2013	6/2017	UNIVERSITY OF COLORADO HOSPITAL	12605 E. 16th Ave. AURORA, CO 80045	AMY HEINZMESCH, MFM FELLOW	Residency Academic Ob/Gyn
2	6/2013	6/2017	DENVER HEALTH & HOSPITAL	777 BANNOCK ST DENVER, CO 80204	TYLER MUFFLY ATTENDING PHYSICIAN	Residency County Ob/Gyn
3	6/2013	6/2017	ROSE HOSPITAL	4567 E. 9TH AVE DENVER, CO 80220	KARA ALEXANDROU ATTENDING PHYSICIAN	Residency Private Practice Ob/Gyn
4						
5						
6						
7						
8						
9						
10						

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, C.R.S., 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.

Applicant Signature — VANLANDINGHAM — Applicant Last Name (print) — 2-28-17 — Date

10/2013

L6

DPO 997

MAR23'17/ 00254

Colorado Division of Professions and Occupations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303) 894-7800 / Fax: (303) 894-7693
www.dora.colorado.gov/professions

CERTIFICATE OF MEDICAL EDUCATION

SECTION 1

To be completed by applicant and forwarded to school where medical degree was received.

This certifies that LINDY ANN VANLANDINGHAM
Full Name of Applicant

enrolled in UNIVERSITY OF COLORADO DENVER SCHOOL OF MEDICINE
Full Name of School

AURORA, CO on the ____ day of AUGUST, 2009.
Location of School Day Month Year

SECTION 2

To be completed by president / secretary / dean of medical school and forwarded to the Office of Licensing.

The undersigned certifies that the records of this institution show that s/he attended this institution beginning on the 10 day of August, 2009 and was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 24 day of May 2013.
Day Month Year

Signed and the college seal affixed

This 16th day of March, 2017.
Day Month Year

By _____
President / Secretary / Dean

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:
If no school seal, please indicate above next to signature of President/Secretary/Dean.

L2

MAR10'17/00181
DPO 985

Colorado Division of Professions and Occupations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303) 894-7800
www.dora.colorado.gov/professions

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

SECTION 1

To be completed by applicant and forwarded to the facility where postgraduate training was received and/or completed.

This certifies that Lindy Ann Vanlandingham
Full Name of Applicant

a graduate of University of Colorado School of Medicine
Full Name of Medical/Osteopathic School

commenced postgraduate training at University of Colorado
Name and Address of Facility

SECTION 2

To be completed by the program director of the facility for ACGME/AOA postgraduate training in the United States or Canada.

on June 23, 2013 and satisfactorily completed or will complete such training on June 22, 2017

This training consisted of 48 months of actual clinical instruction and is approved by the Accredited Council for 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
Obstetrics and Gynecology	48 months

Was this physician's performance completely satisfactory? 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 of level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

Program Director Meredith Alston

Address 12631 E. 17th Ave, B198-4, Aurora, CO 80045

Phone Number 303-724-2052 Date 3/16/17

Signature [signature]

L3

United States Medical Licensing Examination (USMLE)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Recipient: **Date:** 01/29/2017

COLORADO MEDICAL BOARD

Examinee: Vanlandingham, Lindy Ann **Examinee ID:** REDACTED

Alt Name(s): **Date of Birth:** REDACTED

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
4/6/2011	REDACTED		REDACTED	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
9/20/2012	REDACTED		REDACTED	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
9/13/2012	REDACTED			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
5/13/2014	REDACTED		REDACTED	

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	Colorado Medical Board	As of Date:2/27/2017

PRACTITIONER INFORMATION

Name:	Lindy Ann Vanlandingham
DOB:	REDACTED
Medical School:	University of Colorado School of Medicine Denver, Colorado, UNITED STATES
Year of Grad:	2013
Degree Type:	MD

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

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PRACTITIONER PROFILE

Prepared for:	Colorado Medical Board	As of Date:2/27/2017
Practitioner Name:	Lindy Ann Vanlandingham	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards

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Renewal - DR.0058839

Name	Lindy Ann Vanlandingham
Credential	DR.0058839

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
- REDACTED
- REDACTED

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:

03/17/2019

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

Healthcare Professions Profile | Location of Practice

98. Practice Locations:

Address	City	State	Zip Code	Phone Number
425 S Cherry St, #300	Denver	Colorado	80246	(303) 388-4631
8200 E Belleview Ave Suite 320	Englewood	Colorado	80111	(303) 221-1611
4567 E 9th Ave	Denver	Colorado	80220	(303) 320-2121

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

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

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

2013

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?
No

Healthcare Profile - Board Certifications

Healthcare Professions Profile | Board Certifications

103. Do you hold any current Board Certifications?
No

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 Specialties if Yes

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
Rose Medical Center	Admitting Privileges	Denver

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
Women's Health Group	9195 Grant Street	Thornton	Colorado	80229	(303) 280-2229

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 - Restrictions and Suspensions

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 - Convictions

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:

Outstanding obgyn teaching resident 2014, 2015, 2016, 2017 Arnold P Gold Foundation Excellence in Humanism and Teaching Award 2014 CUGME Professionalism Committee Recognition for Exemplary Professionalism 2013

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:

03/17/2019

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.