PAID ~
569.00
1706371

Division of Registrations
**Office of Licensing–Medical**
(303) 894-7800 / Fax (303) 894-7693
www.dora.state.co.us/registrations

Application for License by Endorsement
**PHYSICIAN**
**Fee: $569**

**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.**

**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*.**

## PART 1—APPLICANT INFORMATION

| **Name:** Last: | ☒ MD ☐ DO | First: | Middle: | Suffix: |
|---|---|---|---|---|
| FREDERIKSEN | | MARILYNN | CONNERS | |

**Previous Name(s):** N/A

**Social Security Number:** REDACTED | **Date of Birth** (mm/dd/yyyy) REDACTED | **Gender:** ☐ Male ☒ Female

**Place of Birth** (city and state, or foreign country): CHICAGO, IL

**Mailing Address:** PO Box, Street: 2002 DEVON AVE.
*This is a* ☒ *Home* ☐ *Business* City, State, Zip: PARK RIDGE, IL 60068

**Daytime Telephone Number:** (312) 981-4350 | **E-mail Address:** REDACTED
*Preferred method for communication:* ☐ *Mail* ☒ *E-mail*

## 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 |
|---|---|---|---|
| BOSTON UNIV. MED SCHOOL | 72 E CONCORD BOSTON, MA 02118 | 1970-1974 | 1974 |

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

**U.S. medical school graduates:** Have you completed one (1) year of qualifying postgraduate training in U.S. or Canadian programs approved by the ACGME/AOA? ☒ YES ☐ NO

**International medical school graduates:** Have you completed three (3) years of qualifying postgraduate training in U.S. or Canadian programs approved by the ACGME/AOA? ☐ YES ☐ NO

**Provide information for qualifying postgraduate training:**

| Name of Facility | Specialty | Years Attended (from / to) |
|---|---|---|
| UNIV OF MARYLAND HOSP | PEDIATRICS | 1974 - 1976 |
| BRIGHAM & WOMEN'S HOSP | OB/GYNE | 1976 - 1979 |

**What is your specialty or specialties?** OB/GYNE & MATERNAL-FETAL MEDICINE

***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:** 52797 **DATE ISSUED:** 7/16/13

APPLICANT NAME: FREDERIKSEN, MARILYNN C

## 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 |
|---|---|---|---|
| NAT'L BOARD OF MED EXAMINERS | PHILADELPHIA, PA | 07/01/1975 | REDACTED |

► If this is an international medical school, 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: OB/GYNE 11/05/1982 MATERNAL FETAL MEDICINE 12/05/1983

## PART 4—LICENSE INFORMATION

**Provide information for your original state of medical licensure:**

| Type of license | State/Country | License Number | Year license Issued |
|---|---|---|---|
| PHYSICIAN & SURGEON | ILLINOIS / USA | 036-058725 | 1979 |

## PART 5—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 |
|---|---|---|---|
| | | | |
| | | | |

APPLICANT NAME: FREDERIKSEN, MARILYNN C

## PART 5—SCREENING QUESTIONS (Continued)

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 |
|---|---|---|
| | | |
| | | |

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 |
|---|---|---|---|
| | | | |
| | | | |

APPLICANT NAME: FREDERIKSEN, MARILYNN C

## PART 5—SCREENING QUESTIONS (Continued)

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, such as 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.

**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 |
|---|---|---|
| | | |
| | | |

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 6—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: EXEMPTION D

## PART 7—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 C.R.S. 12-36-140.

APPLICANT NAME: FREDERIKSEN, MARILYNN C

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

Marilynn C Frederiksen
Signature of Applicant

06/18/13
Date

Colorado Division of Registrations
**Office of Licensing—Medical**
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303) 894-7800 / Fax: (303) 894-7693
www.dora.state.co.us/registrations

# REPORT OF PRACTICE HISTORY

| | Dates of Practice From mm/yyyy | To mm/yyyy | Facility Name | Address (Street & Number, City, State, ZIP) | Reference (Name and Title) |
|---|---|---|---|---|---|
| 1 | 07/1979 | 06/1981 | NORTHWESTERN UNIVERSITY NORTHWESTERN MEMORIAL HOSP | 251 E. HURON CHICAGO, IL 60611 | FELLOW MATERAL FETAL MEDICINE |
| 2 | 07/1981 | 07/2011 | NORTHWESTERN MEMORIAL HOSP NORTHWESTERN MED FACULTY FOUNDATION | 251 E. HURON CHICAGO, IL 60611 | ATTENDING PHYSICIAN |
| 3 | 08/2011 | 06/2013 | NORTHWESTERN PERINATAL ASSOC NORTHWESTERN MEMORIAL HOSP. | 680 N LAKE SHORE DR CHICAGO, IL 60611 251 E HURON CHICAGO, IL 60611 | ATTENDING PHYSICIAN |
| 4 | 01/2009 | 12/2010 | SWEDISH AMERICAN HOSPITAL | 1401 east state street ROCKFORD IL, 60104 | Dr. ~~Rex~~ Howard Koffman D.O |
| 5 | 08/2012 | 03/2013 | CARLE FOUNDATION HOSPITAL | 611 W. PARK STREET URBANA IL 61801 | Jamie Bolli Locum Tenens Coordinator |
| 6 | 07/2012 | 08/2012 | WESLEY PHYSICIAN SERVICES DBA MATERNITY | 511 NORTH HILLSIDE STE 330 WICHITA, KS 67214 | DOUNN WILLETT MSO |
| 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 Colorado Revised Statutes 18-8-503, that the information contained in this application is my knowledge. I understand that under the Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical li**

Applicant Signature

FREDERIKSEN, MARILYNN C
Applicant Name (print)

6/18/13
Date

Kansas State Board of Healing Arts
800 SW Jackson, Suite A-Lower Level
Topeka, KS 66612

Phone: 785-296-7413
1-888-886-7205
Fax: 785-296-0852
www.ksbha.org

Kathleen Selzler Lippert
Executive Director

Sam Brownback, Governor

June 19, 2013

Colorado Medical Board
1560 Broadway, Suite 1300
Denver, CO 80202-5140

This is to certify that: Marilynn C Frederiksen has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

| | |
|---|---|
| License Number: | 04-35844 |
| Date of Birth: | REDACTED |
| Profession: | Medical Doctor (MD) |
| License Designation: | MD Active License |
| License Status: | Current |
| Original License Date: | 06/27/2012 |
| Expiration Date: | 06/30/2014 |
| Disciplinary Action: | None |

This license information was last updated on: 06/18/2013

Unless otherwise indicated, this licensee has not been subject to disciplinary proceeding by the Kansas Board of Healing Arts.

Verified by:

Katy Lenahan
Licensing Administrator





BE.

# Welcome to VeriDoc



## Validation

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

**Thank you for using the VeriDoc system.**

**Margie Wyles**

**From:** Angela Cavaness [redacted]
**Sent:** Wednesday, June 19, 2013 3:40 PM
**To:** Board Inquiry
**Subject:** Fed Inq Request for Dr. Marilynn Frederiksen
**Attachments:** Fedex Air Bill - Fed Inq.pdf

6/19/2013

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
PO Box 619850
Dallas, TX 75261-9850

The Colorado State Medical Board requests a disciplinary report on the following individual:

**Name:** Marilynn Conners Frederiksen

**Date of Birth:** [redacted]

**Social Security #:** [redacted]

**Medical School:** Boston University School of Medicine
**Branch Location:** Boston, MA

**Date of Graduation:** 05/1974

Please forward your response to the Board at the following address:

**Colorado Board of Medical Examiners**
**1560 Broadway**
**Suite 1350**
**Denver, CO 80202**

Please use the enclosed prepaid Federal Express air bill to expedite your response. On behalf of Dr. Frederiksen, thank you for your assistance. If you have any questions about this request, please feel free to call me at (800) 328-3065.

**Sincerely,**

**Angela Cavaness**
Licensing Coordinator, CompHealth Locum Tenens
[redacted]
Direct: 801-930-3863 or 800-328-3065 | Fax: 801-930-4512
PO Box 713100 | Salt Lake City, UT 84171-3100

CompHealth.

**Your wish is our command.**

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

JUN 2 0 2013

Humayun J. Chaudhry, D.O., FACP
President and CEO

FORTUNE 100 BEST COMPANIES TO WORK FOR TOP 10 COMPANY

[redacted]

June 14, 2013

Colorado State Board of Medical Examiners
1560 Broadway, Suite 1350
Denver, CO 80202 MD

To Whom It May Concern:

Regarding my application for Colorado medical licensure, I do not have the required malpractice insurance coverage at this time.

However, I currently reside outside of Colorado and claim exemption D set forth in the attached rule. I understand that before I engage in any medical practice in Colorado, I must obtain the required insurance or an acceptable equivalent approved by the State Board. Because I am independently contracted through CompHealth to work in a locum tenens physician capacity, any and all future communications about this issue will also involve the CompHealth team.

Sincerely,

Marilynn Conners Frederiksen, MD

**Colorado Department of Regulatory Agencies**
Division of Registrations
1560 Broadway, Suite 1350
Denver, CO 80202

**Licensee/Applicant Full Legal Name**

| Last | First | Middle | Suffix |
|---|---|---|---|
| FREDERIKSEN | MARILYNN | CONNERS | |

**Colorado Professional or Occupational License/Certification/Registration Number:** _____
(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 | STATE OF ILLINOIS | MARILYNN C FREDERIKSEN | F636-5434-9860 | 09/12/2013 |
| ☐ Government issued ID card | | | | |
| ☐ Valid U.S. military ID/common access card | | | | |
| ☐ Colorado Department of Corrections inmate ID | | | | |
| ☐ Tribal ID card | | | | |
| ☒ U.S. passport | | | | |
| ☐ 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.

MARILYNN C FREDERIKSEN
Print Full Legal Name

Marilynn C Frederiksen
Signature (Full Name)

06/18/2013
Date

# Renewal - DR.0052797

| | |
|---|---|
| Name | Marilynn Conners Frederiksen |
| Credential | DR.0052797 |

## Fee Details

| | |
|---|---|
| DR - Late/Penalty Fee | $15.00 |
| Renewal Fee | $2.00 |
| Renewal Fee | $238.00 |
| Renewal Fee | $18.00 |
| Renewal Fee | $162.00 |
| | **$435.00** |

## 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

## 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:**

- I have not abused or excessively used any habit forming drug, including alcohol, or any controlled substance that has: 1) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or, 2) affected my ability to practice as a physician safely and competently, at any time during the past two years, up to and including today's date.

  AND

  In the last two years, I have not been diagnosed with or treated for an illness or condition that significantly disturbs my cognition, behavior, or motor function, and that may impair my 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

  OR

  The illness or condition or the use of substances, as defined above, is: 1) already known to the Colorado Physician Health Program ("CPHP") and I have made, or will make known within 30 days, any requisite disclosure to the Board pursuant to section 12-36-118.5 and any attendant regulations; or, 2) I have entered into a Confidential Agreement with the Board. For the purpose of this attestation, "Known to CPHP" means that I have informed CPHP of my condition or use of such substances and I am complying with all of CPHP's requirements for evaluation, treatment and/or monitoring.

- 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.0052797

| | |
|---|---|
| Name | Marilynn Conners Frederiksen |
| Credential | DR.0052797 |

## 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 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

## 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:**

- In the past two years I have not abused or excessively used any habit forming drug including, alcohol or any controlled substance, and I have not been diagnosed with or treated for a condition that disturbs my cognition, behavior or motor function which has resulted in an adverse action, a professional disciplinary action, a criminal charge, or an allegation or finding of working impaired, diversion of controlled substances or habit -forming medications (including self-prescribing), sexual contact with a patient, substandard medical practice or patient harm.

OR

In the past two years I have abused or excessively used any habit forming drug including, alcohol or any controlled substance, or I have been diagnosed with or treated for a condition that disturbs my cognition, behavior or motor function

which has resulted in an adverse action, a professional disciplinary action, a criminal charge, or an allegation, or finding of working impaired, diversion of a controlled substance or habit-forming medication (including self-prescribing), sexual contact with a patient, substandard medical practice or patient harm AND I have reported, or will report this information within 30 days to the Colorado Medical Board.

- 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 two years, I have not been diagnosed with or treated for an illness, condition or behavior, that disturbs my cognition, behavior, or motor function that has resulted in conduct which may impair my ability to practice as a physician, safely and competently, such as substance misuse or abuse, bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder.

OR

In the last two years, I have been diagnosed with or treated for an illness, condition or behavior that significantly disturbs my cognition, behavior, or motor function that has resulted in conduct which may impair my ability to practice as a physician, safely and competently, such as substance misuse or abuse, bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder AND:

1) The illness or condition is already known to the Colorado Physician Health Program (“CPHP”) and I have made, or will make known within 30 days, any requisite disclosure to the Board pursuant to section 12-36-118.5 and any attendant regulations; OR

2) I have entered into a Confidential Agreement with the Board. For the purpose of this attestation, “Known to CPHP” means that I have informed CPHP of my condition or use of such substances and I am complying with all of CPHP’s requirements for evaluation, treatment and/or monitoring; OR

3) I have reported, or will report within 30 days, the illness or condition to the Medical Board.

- 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 |
|---|---|---|---|---|
| Shawnee Mission Hospital | Shawnee Mission | Kansas | 66204 | (913) 676-2000 |
| Wesley Hospital | Wichita | Kansas | 67214 | (316) 962-2000 |

## HPPP - MEDICAL Education and Training

**Education and Training**

51. School or Education Level:
Boston University School of Medicine

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

1974

## 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 |
|---|---|---|
| Kansas | Active | 2012 |
| Illinois | Active | 1979 |
| New Mexico | Active | 2016 |

## 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 |
| OBGYN: Maternal and Fetal Medicine |

## 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 |
|---|
| OBGYN: Maternal and Fetal Medicine |

## HPPP GLOBAL - CO Hospital Affiliations

**Colorado Hospital Affiliations**

59. 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**

61. Do you have a current affiliation with any healthcare facility or a non-Colorado hospital?
Yes

## HPPP GLOBAL - Other Hospital Affiliations If Yes

**Other Health Care Facilities and Out of State Hospital Affiliations**

62. Other Healthcare Facility Affiliations:

| Facility | Affiliation Type | City | State |
|---|---|---|---|
| Wesley Memorial Hospital | Other | Wicita | Kansas |
| Shawnee Mission Medical Center | Affiliate | Shawnee Mission | Kansas |

## HPPP GLOBAL - Business Ownership

**Business Ownership**

63. Do you have a current business ownership interest in any healthcare-related business?
Yes

## HPPP GLOBAL - Business Ownership if Yes

**Business Ownership**

64. Business Ownership:

| Business Name | City | State |
|---|---|---|
| Northwestern Perinatal Associates | Chicago | Illinois |

## 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 |
|---|---|---|---|---|---|
| Comp Health | 6440 S. Millrock Dr., Suite 175 | Salt Lake City | Utah | 84121 | (801) 930-3610 |

## 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 Refusal

**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:
Rodger Baldwin Award from the ACLU 1991.

## 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:
04/18/2017

## 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.