COLORADO STATE BOARD OF MEDICAL EXAMINERS

APPLICATION FOR A PHYSICIAN TRAINING LICENSE **FEE $20.00**

READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS APPLICATION. ALL QUESTIONS MUST BE ANSWERED, AND ALL SUPPORTING DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION PER INSTRUCTIONS. THE ENCLOSED CHECKLIST IS PROVIDED FOR YOUR CONVENIENCE. PLEASE TYPE OR PRINT NEATLY. **WHEN SPACE PROVIDED IS INSUFFICIENT, ATTACH ADDITIONAL SHEETS IF NECESSARY.**

1 a. Name: Last: Dempsey | First: Angela | Middle: Richardson | Degree: M.D.

1b. Social Security Number: REDACTED

2. Other names (i.e. maiden name)- indicate if none.
none

3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE, Address provided is, by law, public information.)
☑ Home
☐ Business
145 West 3rd Ave Denver, CO 80223

City: Denver | State: CO | Zip: 80223 | Country: U.S.A.

e-mail address: REDACTED

4. Telephone Number: (Area Code) Day: 720-570-0498 | Evening:

5. Date of Birth: Mo/Day/Year: REDACTED

6. Sex: Male / (Female — circled)

7. Have you ever filed an application in Colorado?
☐ Yes If yes, give date of previous application
☑ No

8. List name/address of the school where medical degree was received.

Name of School	City and State	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
Medical University of S.C.	Charleston, SC		
~~University of Colorado~~ ARD	~~Denver, CO~~ ARD	~~6-02~~ ARD	~~6-05~~ ARD

9. List the name and address of the Colorado training program into which you have been accepted.

Name: University of Colorado Health Sciences Center 8/98 5/02
Address: 4200 East 9th Ave. Box B-198 Denver, CO 80262

10. Have you received and/or completed postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs?
☐ Yes If yes, provide information below.
☑ No

Name of facility	Specialty	Period of attendance From (Mo/Yr)	To (Mo/Yr)

11. Are you now or have you ever been licensed to practice medicine in any state, territory, district or country? **Include temporary licenses and educational permits.** Request verification from each to be sent to the Colorado Board.
☐ Yes If yes, provide information below.
☑ No

State or country	License #	Dates of Practice in this jurisdiction: Issue Date	Expiration Date

12. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic board of any complaint, investigation or inquiry, which is **currently pending?**
☐ Yes If yes, give details below.
☑ No

State	Date	Charge	Disposition

13. Has **any disciplinary action** ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity? (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question.
☐ Yes If yes, give details below.
☑ No

State	Date	Charge	Disposition

Official Use Only	License#: TL [illegible]	Date: 8/7/02
Revised 10/99	Fee $: 20	Date: 6/24/02

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