APR2015/C0373

DIV. OF REGISTRATIONS 334

Division of Professions and Occupations
Office of Licensing–Medical
(303) 894-7800 / Fax (303) 894-7693
www.dora.colorado.gov/professions

PAID
10.00-LSN
1452389

Application
PHYSICIAN TRAINING LICENSE
Fee: $10

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:
Fang		Nancy	Zhiyu	

Previous Name(s):

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

Place of Birth (city and state, or foreign country): Boston, MA

Mailing Address: PO Box, Street: 511 Hudson Road
This is a ☒ *Home* ☐ *Business* City, State, Zip: Sudbury, MA 01776

Daytime Telephone Number: (508) 733-6187 | **E-mail Address:** REDACTED
Preferred method for communication: ☐ *Mail* ☒ *E-mail*

PART 2—EDUCATION / TRAINING PROGRAM

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

Name of School	Location (city and state)	Years Attended (from / to)
University of Pittsburgh SOM	Pittsburgh, PA	2011-2015

List information about the specialty program into which you have been accepted:

Name of School	Address	Telephone Number	Start Date in Program
University of Colorado SOM	12631 E. 17th Ave., Aurora, CO 80045	(303)-724-2052	6/23/2015

Is the training position you are filling a:
- ☒ CATEGORICAL – a permanent position for the duration of your program?
- ☐ PRELIMINARY NON-DESIGNATED – you have not yet matched into a permanent program?
- ☐ PRELIMINARY DESIGNATED – from which you will transfer to _____ upon completion?
  (name/location of subsequent program)

Have you received and/or completed additional postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs in addition to the program listed above? ☐ YES ☒ NO

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

Name of Facility	Specialty	Years Attended (from / to)

***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 § 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 § 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the National Practitioner Data Bank pursuant to 45 CFR §§ 60.1 et seq., and the Health Integrity and Protection Data Bank as required by 45 CFR §§ 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:** [illegible] **DATE ISSUED:** 4/27/15

APPLICANT NAME: Nancy Fang

PART 3—LICENSE INFORMATION

A. Have you ever been licensed to practice medicine in any state, territory, district, or country? (including 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?
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

B. Have you ever filed an application in Colorado? ☐ YES ☒ NO

► If **YES**, give date of previous application: _____

PART 4—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: Nancy Fang

PART 4—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.

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.)

APPLICANT NAME: Nancy Fang

PART 4—SCREENING QUESTIONS (Continued)

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,** list below and complete the attached Claims Information Form.

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 5—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.

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 understand that this license will apply only to the training program I am currently entering, and will only be transferable to a subsequent program if I am currently matched into that subsequent program as a requirement of my training program. I will not practice in any other subsequent training program until a new valid training license has been issued to me.

I understand that this license will only be valid for the training program listed within this application, and should I wish to practice medicine in Colorado outside the training environment, I would need to apply for a license to practice medicine in the state of Colorado.

I further understand that the issuance of this training license is not a guarantee of issuance of a license to practice medicine in the state of Colorado.

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.

Applicant Signature

3/26/2015
Date

TRAINING PROGRAM STATEMENT

This statement to be completed by Program Director, Clinical Director, or Training Supervisor.

NOTE: If a separate statement has already been submitted to the Board, this section does not need to be completed. Please check with your training program to see if this information has been submitted to the Colorado Medical Board.

Name of Colorado Training Program / Specialty:

University of Colorado / Obstetrics and Gynecology

Address of Training Program:

12631 E. 17th Ave, B198-6, Aurora, CO 80045

I certify that this applicant meets the criteria set forth in C.R.S. 12-36-122 (2)(a), and that the training program indicated above will accept responsibility for the applicant's medical training while in the program.

This applicant is filling a

- ☒ CATEGORICAL – a permanent position for the duration of their program.
- ☐ PRELIMINARY NON-DESIGNATED – they have not yet matched into a permanent program.
- ☐ PRELIMINARY DESIGNATED – from which they will transfer to the following upon completion:

(Name / location of subsequent program)

As the Program Director, I understand that upon completion of the program, I have the responsibility to notify the Board that this applicant has completed their training in my program and will also advise the Board if the applicant is entering a subsequent training program after completion of the preliminary year(s). I further understand, and will advise the applicant, that if they are in a preliminary program attested to by my signature, that a signed attestation from the Program Director of the categorical (permanent) program must be submitted to the Board within 60 days of starting in that program, or their license will expire and they will need to reapply.

Signature of Program Director, Clinical Director, or Supervising Physician of Colorado Training Program (must be a Colorado licensed physician) — Date: 4/8/15

Meredith Alston, MD — Print name

45474 — Colorado license number

Christine Raffaelli — Name of contact for program

303-724-2052 — Program contact phone number

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
Fang	Nancy	Zhiyu	

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

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

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	Pennsylvania	Nancy Zhiyu Fang	31251381	12/15/2015
☐ 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.

Nancy Zhiyu Fang
Print Full Legal Name

Signature (Full Name)

3/26/2015
Date

Renewal - TL.0005665

Name	Nancy Zhiyu Fang
Credential	TL.0005665

Fee Details

TL - Legal Defense Fund	$2.00
TL - Portal Fee	$1.50
TL - Renewal Fee Active	$9.50
	$13.00

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:

- 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 CPHPs 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.

Select "Next" to proceed.

Healthcare Profile - Physician Training License Introduction

Healthcare Professions Profile | Introduction

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.

Healthcare Profile - Location of Practice

Healthcare Professions Profile | Location of Practice

49. 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

50. Practice Locations:

Address	City	State	Zip Code	Phone Number
12631 E 17th St	Aurora	Colorado	80045	(303) 724-2052

790 Bannock St	Denver	Colorado	80204	(303) 602-9728
4567 E. 9th Avenue	Denver	Colorado	80220	(303) 320-2484

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

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

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

2015

Healthcare Profile - Other Licenses

Healthcare Professions Profile | 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?
No

Healthcare Profile - Board Certifications

Healthcare Professions Profile | Board Certifications

55. Do you hold any current Board Certifications?
No

Healthcare Profile - Practice Specialties

Healthcare Professions Profile | Practice Specialties

57. 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

58. Practice Specialties:

Specialty
Obstetrics and Gynecology

Healthcare Profile - Colorado Hospital Affiliations

Healthcare Professions Profile | Colorado Hosptial Affiliations

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

Healthcare Profile - Other Facility and Out of State Hospital Affiliations

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

61. 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

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

Healthcare Profile - Employer

Healthcare Professions Profile | Employer

65. 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

66. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
University of Colorado School of Medicine	12631 E 17th Ave	Aurora	Colorado	80045	(303) 724-2052

Healthcare Profile - Employment Contracts

Healthcare Professions Profile | 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

Healthcare Profile - Disciplinary Actions

Healthcare Professions Profile | 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

Healthcare Profile - Restrictions and Suspensions

Healthcare Professions Profile | 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

Healthcare Profile - Healthcare Facility Actions

Healthcare Professions Profile | 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

Healthcare Profile - Termination of Employment

Healthcare Professions Profile | 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

Healthcare Profile - DEA Registration

Healthcare Professions Profile | DEA Registration

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

Healthcare Profile - Convictions

Healthcare Professions Profile | 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

Healthcare Profile - Malpractice Claims

Healthcare Professions Profile | 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

Healthcare Profile - Malpractice Carrier Refusal

Healthcare Professions Profile | 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

Healthcare Profile - Optional Narrative

Healthcare Professions Profile | Optional Narrative

86. Optional Narrative:

Healthcare Profile - Attestation

Healthcare Professions Profile | Attestation

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

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

87. Submission Date:

08/15/2018

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.

CREDENTIAL STATUS HISTORY SUMMARY

Name: Nancy Zhiyu Fang **Date:** 7/20/2021
License: Physician Training License TL.0005665
License Status: Application Expired
License Status Reason: APPLICATION EXPIRED
First Issuance date: 05/27/2015
License expiration date: 08/31/2021

This is to certify that a good faith search of our records revealed the following information:

Status	Reason	Date Changed	User
Application Expired	APPLICATION EXPIRED	06/24/2021	Automated
Active	CURRENT	08/15/2018	Automated
Active in Renewal	ACTIVE	08/07/2018	Automated
Active	CURRENT	05/27/2015	Automated
Active in Renewal	ACTIVE	08/07/2018	Automated
Active	CURRENT	05/27/2015	Automated
Approved	READY TO PRINT	05/27/2015	Automated
Pending	QUALITY ASSURANCE	05/27/2015	Automated
Pending	INTERNAL CONTROL APPROVAL	05/22/2015	Automated
Application Incomplete	APPLICATION INCOMPLETE	04/30/2015	Automated
Pending	PENDING CHECKLIST		Automated

Application - Physician

Name	Nancy Zhiyu Fang
Credential	Physician

Fee Details

DR - Original License Fee	$275.00
DR - Peer Fee Application	$140.00
	$415.00

Physician - Welcome

Physician Application | Welcome

Please complete the information on the following pages. All questions with a red asterisk (*) are required.

Welcome to Online Physician Application. Before you begin, please review the important information below:

There are two methods you may use to become licensed. To apply by one of the available methods you will have to have already completed, or have in your possession verification of the below. Please use the links below for the specific requirements:

- **Physician by Original**
  - Graduation from an approved medical college. If you have not graduated yet, do not apply.
  - Completion of at least 1 year of an internship or post graduate training approved by the Colorado Medical Board. If you have not completed at least 1 year, do not apply.
  - Have achieved a passing score on the appropriate examination(s). If you have not achieved a passing score yet, do not apply.
- **Physician by Endorsement**
  - Hold or have held an active license as a physician in another state or jurisdiction. If you do not currently hold or previously held a physician license, do not apply.
  - Have practiced as a physician in another state or jurisdiction for 5 of the past 7 years. If you have not, do not apply.

Basically, if you don't have the above, it is best for you to wait until you can secure it. Otherwise you will not be able to qualify for a Physician license. We'll ask more specific information later in the application about the above items. Remember, you can stop and cancel this application at any time before submitting. However, if you submit the application, pay the fee and do not provide the information as requested, submit incomplete documentation or do not qualify, your application may be rejected and no refunds or transfers will be given.

Still ready to go? OKAY, let's start by selecting the "Next" button below.

Application - Applicant Information

Application | Applicant Information

1. To begin, we need to know a little more about you. The questions below help us to learn about you and provide some information needed in order to process your application as quickly and efficiently as possible.

Have you ever had a legal name change, used an alternate name in the past or have you ever practiced under a different name than you registered your account with?

If you answer yes, you will be prompted on the next page to provide your other name(s) and upload any necessary name change documentation.

No

2. What is your Date of Birth?

REDACTE

3. Optional - What Gender do you identify with?

Female

4. What is your Birth City?

Boston

5. What is your Birth State?

(If born outside of the United States, select "Foreign Country" in the dropdown below)
Massachusetts

6. What is your Birth Country?
United States

Application - Military

Application | Military

9. Are you an active member of the U.S. Military, National Guard or Military Reserves?
No

10.

- If yes to the above, what branch of the military are you currently serving in?

11.

- If yes to the above, what is the Duty Station you are located at?

12. Are you a Veteran of the U.S. Military?
No

13.

- If yes to the above, what was the date of your discharge from the U.S. Military?

14. Are you the spouse of an active military member who has been relocated to Colorado AND currently hold a valid and Active credential to practice your profession in another U.S. state?
No

*Affidavit of Eligibility Lawful Presence

Affidavit of Eligibility | Section A: Lawful Presence

15. To qualify for an occupational license or registration in Colorado, you must be legally allowed to work in the United States. You will need to answer the following questions to establish your lawful presence. Please select the lawful presence that you qualify for:
I am a U.S. Citizen

16. Select your physical presence:
I am physically present in the U.S.

*Affidavit of Eligibility Documents

Affidavit of Eligibility | Section B: Verification Documents

17. To prove your eligibility to work in the United States, you need to present a valid, government issued form of identification. Please select which type of document you will be uploading within this section.

Note: If you selected "I am NOT a US Citizen" in the prior section you may only select a document that has an asterisk (*) at the option.

Out of State Drivers License or Identification Card

18. Please upload an image of the document that you selected in the prior question. The image must include the full document and the print must be readable or your application process time will be delayed.

This upload option will only allow for 2MB file size. Preferences to shrink an image file if it is too large:

- Make the image black and white.
- Crop the image - allowing for only the document to be seen.
- Compress the image.
- Change the image resolution.

To upload a document, select the "Browse" button to search for the scanned document on your computer. After deciding which document to use, select the "Upload Documents" button to complete uploading the document to your application.

REDACTED

*Affidavit of Eligibility Attestation

Affidavit of Eligibility | Section C: Attestation

19. By submitting this Affidavit of Eligibility (AoE) I am attesting that I have read and understand the 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.

As verification to these statements, enter today's date:

06/09/2021

Physician - School and Method

Physician Application | Education/School Information

20. Enter the name of the approved, medical college or university from which you graduated:

University of Pittsburgh School of Medicine

21. Enter the address of the college or university (Street, City, State and Zip):

3550 Terrace St, Pittsburgh, PA 15213

22. How many years did you attend this college or university?:

4

23. Enter the date you graduated:

05/18/2015

24. Enter your title:

Medical Doctor

25. Is the above medical college or university based in a foreign country (non-United States)?

No

26.

- If you said "yes" to the question above and your medical college or university is based in a foreign country, you must attest to the below:
    - Your school's medical program has been approved by the Liaison Committee or Medical Education (LCME) or the American Osteopathic Association (AOA); OR
    - Your school is not approved by the LCME or AOA but you wish the board to conduct it's own investigation of the educational standards and facilities (Note* if not approved by the board, you may not be eligible for licensure): OR
    - You hold a current specialty board certification conferred by the American Board of Medical Specialties or the American Osteopathic Association;
      AND
    - You have at least 3 years post graduate training approved by the Colorado Medical Board verified with a Certificate of Completion.

27. Ready to move on? Great!

To move on to the next part of the application select your license method in the drop-down box below. Remember you can apply via:

- **Physician by Original**
- **Physician by Endorsement**

Original

Physician - Original Information

Physician Application | Original Information

28. Please upload a copy of your Certificate of Completion of your internship or post graduate training from the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) or the Coordinating Council for Medical Education of the Canadian Medical Association (CCME) .

- United States medical school graduates must reflect 1 year of internship or post graduate training
- Foreign medical school graduates must reflect 3 years of post graduate training

Again, if you cannot supply the above documentation, you cannot apply.

Select the "Choose File" button to search for the scanned document(s) on your computer. After deciding which document to use, select the "Upload Document" button to complete uploading the document(s).

Fang_Residency Certificate_UColorado.pdf

29. Please list, in chronological order including specific dates (format: mm/yy - mm/yy), your practice history for the last 2 years. This history should include: Internships, post-graduate training, residency, fellowship training programs as well as any non-medical employment.

Fellowship in Complex Family Planning at Columbia University Irving Medical Center- 07/19-06/21

30. Have you completed and passed an examination approved by the Colorado Medical Board (CMB), the National Board of Medical Examiners (NBME), the National Board of Osteopathic Medical Examiners (NBOME), or the Federation of State Medical Boards (FSMB)?

RE

31. You must arrange for the appropriate examining agency (Medical or Osteopathic National Boards, FLEX, USMLE, LMCC or State Written Exam) to send verification of your passing scores to our office. To arrange for this verification, please contact the agency and request your scores be sent to our office at:

- **dora_dpo_licensing@state.co.us**

Have you arranged for verification of passing scores to be sent to our office?

RE

32. Do you currently hold or have you ever held a physician license in Colorado or any other state?

Yes

33.

- If you said "yes" to the question above you must list ALL licenses below:

Name of License Holder	State	LicenseType	LicenseNumber	License Status	LicenseIssuedDate	License Expiration Date	Disciplinary Action	Type of Endorsement (s)
Nancy Fang	New York	Medical	296981	Active	11/30/2018	11/30/2021	No	
Nancy Fang	Colorado	Physician Training License	TL.0005665	Active	08/31/2018	08/31/2021	No	

34.

- If you said "yes" to the question above you must also scan and upload verification ALL licenses (including Training Licenses) below:

  This verification can be a screen capture from another state website, but must indicate the original issue date and show any disciplinary actions that have been taken against your license. If you are unable to access verification from another state site, you will need to request one from them and upload it here. *Pictures or copies of Wallet Cards/Wall Certificates are not sufficient. Do not apply if you cannot supply this verification.

  Select the "Choose File" button to search for the scanned document(s) on your computer. After deciding which document to use, select the "Upload Document" button to complete uploading the document(s).

NY medical license exp 2021.pdf
CO Training License_exp083121.pdf

35.

- If you said "yes" to the question above you must also scan and upload any National Practitioner Data Bank (NPDB) certified report, pending or final disciplinary action or malpractice actions against any license you hold or have ever held in any state or jurisdiction.

  The NPDB report must be dated within four months of submission of this application. To obtain this report you may contact NPDB through their website: **www.npdb.hrsa.gov**.

If you have never held an active Physician license before, you do not need to submit this report.

Select the "Choose File" button to search for the scanned document(s) on your computer. After deciding which document to use, select the "Upload Document" button to complete uploading the document(s).

REDACTED

36. You must arrange for your Physician Initiated Profile Request to be sent to our office from the Federation of State Medical Boards (FSMB). This report will be electronically submitted to the Colorado Medical Board upon your request. There is no fee for this request and you will receive an email confirmation from FSMB when completed. To complete this request you must login/create an account at: **FSMB Physician Initiated Profile Request**.

Once in your FSMB account you will need to complete the process to have the FSMB Report sent to our office.

Have you arranged for your FSMB Physician Initiated Profile Report to be sent to our office?
Yes

37. Prior to practicing as a licensed Physician in Colorado, you must complete the following:

- Obtain Professional Liability Insurance, or be covered by an exemption; AND
- Develop a written plan to ensure the security of patient medical records

You may review the laws and rules regarding professional liability and security of patient medical records on the **Physician Laws, Rules and Policies webpage.**

By selecting "Yes" below, you are attesting that you have obtained or will obtain, prior to practicing in Colorado, professional liability insurance or that you are covered by an exemption AND that you have developed a written patient medical records security plan.
Yes

Application - Screening MEDICAL Questions

Application | Screening Questions

If you select "Yes" to any of the questions below, please complete the additional explanation questions at the bottom of this screen.

Within the past five years, have you engaged in any conduct or exhibited any behaviors that resulted in:

48.

- An arrest, discipline, sanction or warning?

No

49.

- Loss or suspension of any license?

No

50.

- Termination or suspension from school or employment?

No

51.

- Endangering the safety of others?

No

52.

- A breach of fiduciary obligations?

No

53.

- A violation of workplace or academic conduct rules?

No

54.

- An impairment of your ability to practice in a safe, competent, ethical and professional manner?

You may answer No if you have been formally evaluated by Colorado Physician Health Program (CPHP) and you are in compliance with all CPHP's requirements for treatment and/or monitoring. The Board recognizes that licensed medical professionals encounter physical and mental health conditions, including those involving substance use disorders The Board expects its licensees to address any health concerns to ensure their wellness and patient safety. As a licensee, you have the benefit of proactively and confidentially, self-referring to the ***Colorado Physician Health Program (CPHP)*** *at no cost to address any health concerns, including psychosocial matters such as burnout and family problems. CPHP is the peer assistance program dedicated to improving the health and wellness of licensed medical professionals in a confidential manner.*

Participation in the CPHP program does not eliminate any licensee's reporting responsibilities to the Board. Failure to adequately report and address a health condition that impacts the licensee's ability to practice with reasonable skill and safety may result in the Board taking action against the license to practice.

By answering this question you are attesting that you have read and understand the above advisory.

R

55.

- Abusing or excessively using any habit forming drug, including alcohol, or any illegal or controlled substance resulting in any discipline for misconduct, failure to meet professional responsibilities, or affecting your ability to practice safely and competently?

You may answer No if you have been formally evaluated by Colorado Physician Health Program (CPHP) and you are in compliance with all CPHP's requirements for treatment and/or monitoring. The Board recognizes that licensed medical professionals encounter physical and mental health conditions, including those involving substance use disorders The Board expects its licensees to address any health concerns to ensure their wellness and patient safety. As a licensee, you have the benefit of proactively and confidentially, self-referring to the ***Colorado Physician Health Program (CPHP)*** *at no cost to address any health concerns, including psychosocial matters such as burnout and family problems. CPHP is the peer assistance program dedicated to improving the health and wellness of licensed medical professionals in a confidential manner.*

Participation in the CPHP program does not eliminate any licensee's reporting responsibilities to the Board. Failure to adequately report and address a health condition that impacts the licensee's ability to practice with reasonable skill and safety may result in the Board taking action against the license to practice.

By answering this question you are attesting that you have read and understand the above advisory.

R

56.

- Claiming the illegal use of a substance as a defense, in mitigation, or as an explanation for any conduct that impairs your ability to practice in a safe, competent, ethical, and professional manner?

  You may answer No if you have been formally evaluated by Colorado Physician Health Program (CPHP) and you are in compliance with all CPHP's requirements for treatment and/or monitoring. The Board recognizes that licensed medical professionals encounter physical and mental health conditions, including those involving substance use disorders The Board expects its licensees to address any health concerns to ensure their wellness and patient safety. As a licensee, you have the benefit of proactively and confidentially, self-referring to the ***Colorado Physician Health Program (CPHP)*** *at no cost to address any health concerns, including psychosocial matters such as burnout and family problems. CPHP is the peer assistance program dedicated to improving the health and wellness of licensed medical professionals in a confidential manner.*

  Participation in the CPHP program does not eliminate any licensee's reporting responsibilities to the Board. Failure to adequately report and address a health condition that impacts the licensee's ability to practice with reasonable skill and safety may result in the Board taking action against the license to practice.

  By answering this question you are attesting that you have read and understand the above advisory.

No

For each "yes" response above you will be required to provide:

- **A description and explanation of the behavior(s) or practice(s)**
- **Dates of the event(s)**
- **Locations(s)/Court(s)**
- **Current status(es)/outcome(s)**
- **Any accompanying documentation**

Please make sure to provide as much information as possible. Any missing information will cause a delay in processing and could result in rejection of the application.

57. Provide a brief description and explanation of your behavior or practice that led to the issues noted above:

58. Enter the date(s) of the event(s)/offense(s):

59. Enter the location(s)/court(s):

60. Provide the current status/outcome of the event(s)/offense(s):

61. Upload copies of ALL accompanying documentation related to the issues noted above. This includes but not limited to:

- Copies of legal documents relating the event/offense
- Copies of legal documents indicating your compliance with any requirements imposed upon you
- Copies of court documents

Select the "Choose File" button to search for the scanned document(s) on your computer. After deciding which document(s) to use, select the "Upload Document" button to complete uploading the document(s).

Application - Screening Inquiry Questions

Application | Screening Questions

If you select "Yes" to any of the questions below, please complete the additional explanation questions at the bottom of this screen.

Have you ever had any inquiry, investigation or administrative/judicial proceeding by:

62.

- A Licensing Authority other than a Colorado State Board or Program?

No

63.

- A Government Agency?

No

64.

- A Court?

No

65.

- An Employer?

No

66.

- An Educational Institution?

No

67.

- A Professional Organization?

No

68.

- In connection with an employment disciplinary or termination procedure?

No

For each "yes" response above you will be required to provide:

- **A description and explanation of the behavior(s) or practice(s)**
- **Dates of the event(s)**
- **Locations(s)/Court(s)**
- **Current status(es)/outcome(s)**
- **Any accompanying documentation**

Please make sure to provide as much information as possible. Any missing information will cause a delay in processing and could result in rejection of the application.

69. Provide a brief description and explanation of your behavior or practice that led to the issues noted above:

70. Enter the date(s) of the event(s)/offense(s):

71. Enter the location(s)/court(s):

72. Provide the current status/outcome of the event(s)/offense(s):

73. Upload copies of ALL accompanying documentation related to the issues noted above. This includes but not limited to:

- Copies of legal documents relating the event/offense
- Copies of legal documents indicating your compliance with any requirements imposed upon you
- Copies of court documents

Select the "Choose File" button to search for the scanned document(s) on your computer. After deciding which document(s) to use, select the "Upload Document" button to complete uploading the document(s).

Application - Screening Medical Healthcare Questions

Application | Screening Questions

If you select "Yes" to any of the questions below, please complete the additional explanation questions at the bottom of this screen.

Have you ever had the below occur:

74.

- Been refused malpractice insurance, had malpractice insurance cancelled or rated at a higher premium due to past claims experience?

No

75.

- Additionally, within the last 5 years, has any medical malpractice claim been filed against you that is still pending?

No

76.

- Had your staff membership or clinical privileges at any hospital or healthcare facility, or your DEA registration been reduced, limited, placed on probation, not renewed, relinquished, denied, revoked or suspended?

No

For each "yes" response above you will be required to provide:

- **A description and explanation of the behavior(s) or practice(s)**
- **Dates of the event(s)**
- **Locations(s)/Court(s)**
- **Current status(es)/outcome(s)**
- **Any accompanying documentation**

Please make sure to provide as much information as possible. Any missing information will cause a delay in processing and could result in rejection of the application.

77. Provide a brief description and explanation of your behavior or practice that led to the issues noted above:

78. Enter the date(s) of the event(s)/offense(s):

79. Enter the location(s)/court(s):

80. Provide the current status/outcome of the event(s)/offense(s):

81. Upload copies of ALL accompanying documentation related to the issues noted above. This includes but not limited to:

- Copies of legal documents relating the event/offense
- Copies of legal documents indicating your compliance with any requirements imposed upon you
- Copies of court documents

Select the "Choose File" button to search for the scanned document(s) on your computer. After deciding which document(s) to use, select the "Upload Document" button to complete uploading the document(s).

Physician - Attestation

Physician Application | Attestation

82. By submitting this online application you attest to the following statements:

- The information contained in this application is true and correct to the best of my knowledge.
- False statements made on my application could result in a violation of the practice act.

Additionally, this is a final reminder that you are submitting a Physician application. If you submit the application and do not provide the information as requested, submit incomplete documentation, submit the wrong application or do not qualify, your application may be rejected. You will NOT be allowed to transfer fees and there will be NO REFUNDS given.

Please enter today's date below and select the "Next" button to agree to the above conditions:
06/09/2021

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

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

Yes

Healthcare Profile - Location of Practice if Yes (WF)

Healthcare Professions Profile | Location of Practice

84. Practice Locations:

Address	City	State	Zip Code	Phone Number
622 West 168th Street, PH 16-69	New York	New York	10032	2123054938

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

85. School or Education Level:
University of Pittsburgh School of Medicine

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

2015

Healthcare Profile - Other Licenses

Healthcare Professions Profile | Other Licenses

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

Yes

Healthcare Profile - Other Licenses if Yes

Healthcare Professions Profile | Other Licenses

88. Other Licenses:

State	License Status	Year Originally Issued
New York	Active	2018

Healthcare Profile - Board Certifications

Healthcare Professions Profile | Board Certifications

89. Do you hold any current Board Certifications?
Yes

Healthcare Profile - Medical Board Certifications if Yes

Healthcare Professions Profile | Board Certifications

90. Board Certifications:

Certification
Obstetrics and Gynecology

Healthcare Profile - Practice Specialties

Healthcare Professions Profile | Practice Specialties

91. 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

92. Practice Specialties:

Specialty
Other

Healthcare Profile - Colorado Hospital Affiliations

Healthcare Professions Profile | Colorado Hospital Affiliations

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

Healthcare Profile - Other Facility and Out of State Hospital Affiliations

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

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

Healthcare Profile - Other Facility and Out of State Hospital Affiliations if Yes

Healthcare Professions Profile | Other State Hospital Affiliations

96. Other Healthcare Facility Affiliations:

Facility	Affiliation Type	City	State
Columbia University Irving Medical Center	Faculty	New York	New York

Healthcare Profile - Business Ownership

Healthcare Professions Profile | Business Ownership

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

Healthcare Profile - Employer

Healthcare Professions Profile | Employer

99. 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

100. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
Columbia University Irving Medical Center	622 West 168th Street	New York	New York	10032	(212) 305-4938

Healthcare Profile - Employment Contracts

Healthcare Professions Profile | Employment Contracts

101. 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

103. 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

105. 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

107. 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

109. 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

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

Healthcare Profile - Convictions

Healthcare Professions Profile | Convictions

114. 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

116. 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

118. 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

120. Optional Narrative:

Healthcare Profile - Attestation

Healthcare Professions Profile | Attestation

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

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

121. Submission Date:
06/09/2021

Review

It's a good idea to print this screen for your records as after you submit your application you will not be able to access it again. To do so follow the below steps:

- Select the "Print Review" button in the upper right hand corner of this page
- The Print Review window will open in a new browser tab. In that window select "Print" and your document will print to your selected printer.
- After printing, close the Print Review browser tab.

After you close the Print Review tab, you will be returned to this page and can complete your submission.

CREDENTIAL STATUS HISTORY SUMMARY

Name: Nancy Zhiyu Fang **Date:** 7/20/2021
License: Physician DR.0066877
License Status: Active
License Status Reason: CURRENT
First Issuance date: 06/24/2021
License expiration date: 04/30/2023

This is to certify that a good faith search of our records revealed the following information:

Status	Reason	Date Changed	User
Active	CURRENT	06/24/2021	Automated
Pending	QUALITY ASSURANCE	06/24/2021	Automated
Pending Supervisor Review	PENDING SUPERVISOR REVIEW	06/24/2021	Automated
Online Application Received	ONLINE APPLICATION RECEIVED		New License