STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690 V/TDD (303) 894-2900 ext. 833
FAX: (303) 894-7692

BOARD OF MEDICAL EXAMINERS
APR 26 1999
STATE OF COLORADO

5266

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE

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

OFFICE USE ONLY

PERSONAL DATA

1a. Name: Last: ARON, First: ELISABETH Middle: A Degree: MD

1b. Social Security Number: REDACTED

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

NONE

L7 ☒

3. Mailing Address: Number and Street/Rural Route, Apartment Number: 235 W 75th st Apt 12G This is my home ☒ business ☐

NPDB ☒

City: NY State: NY Zip: 10023 Country: USA

e-mail address:

4. Telephone Number: (Area Code) Day: 212 579-6097 Evening

5. Date of Birth: Mo/Day/Year REDACTED Place of Birth: New York, NY

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

BC ☒

6. Sex: Male ☐ Female ☒

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

If yes, give date of previous application

PRE-MED EDUC

8. List name and address of college or university where pre-medical degree was received.

Name of School	Address and zip	Period of attendance From (Mo/Yr)	To (Mo/Yr)
VASSAR COLLEGE	POUGHKEEPSIE, NY 12601	8/84	6/88

MEDICAL EDUC L2 ☒

9. List name and address of the school where professional medical degree was received.
Request an original L2 Form (Certificate of Medical Education). Certificate must be sent directly from the school to this office.

Name of School	Address and zip	Period of attendance From (Mo/Yr)	To (Mo/Yr)
ALBERT EINSTEIN	BRONX, NY	8/88	6/92
COLLEGE OF MEDICINE	1300 Morris Park Ave		
	Bronx, NY 10461		

Org. 8/86
Revised 9/92
Revised 11/95
Revised 4/96
Revised 12/96
Revised 1/97
Revised 11/98

Official use only
License # 27913 Date 7/22/99
Fee$ 275.- Date 4/26/99

1-203

L1A

OFFICE USE ONLY

10. Have you ever taken any of the following written examinations: ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam?
If yes, request certification of scores from examining agency be sent directly to this office. If you did not take a national exam (i.e. FLEX, NBME, NBOME, USMLE, LMCC) then request verification and scores from the state examinating agency. (See " Summary of Requirements") Provide information below:

WRITTEN EXAM

Exam	Location	Date	Result
NBME I	NY, NY	6/12/90	[redacted]
I	NY, NY	6/11/91	
II	NY, NY	9/25/91	
III	NY, NY	5/19/93	

11. Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian facilities?
☑ Yes ☐ No
If yes, provide information below. Request an original L3 Form (Certificate of Completion of ACGME/AOA Postgraduate Training) from each facility attended for internship and residency training.

POSTGRAD TRAINING

Name of facility	Address and zip	Specialty	Period of attendance: From (Mo/Yr)	To (Mo/Yr)
ST. LUKE'S/ROOSEVELT	NEW YORK, NY	OB/GYN	7/92	6/96
HOSPITAL CENTER	1000 Tenth Ave			
	NY NY 10019			

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

LICENSE DATA

State or country	License number	Date of issue	Dates of practice in this jurisdiction: From (Mo/Yr)	To (Mo/Yr)
NEW YORK	198226	1/17/95	1/17/95	present

13. Are you now or have you ever practiced medicine in any state, territory, district, or country, U.S. Military, U.S. Public Health, or any U.S. government agency? ☑ Yes ☐ No (See Form L6 - Report of Practice History)

L6 ☒

14. 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 ☑ No
If yes, give details below:

State	Date	Charge	Disposition

REQ REC

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

State or government agency	Date	Charge	Disposition

REQ REC

OFFICE USE ONLY

LICENSE DATA (continued)

BOARD OF MEDICAL EXAMINERS
APR 26 1999
STATE OF COLORADO

16. Have you ever entered into any agreement with any state, territory, district, country, U.S. government agency, state medical, osteopathic board regarding your medical license?

☐ Yes ☑ No

If yes, give details below:

Agency	Date	Reason	REQ	REC
			☐	☐
			☐	☐

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

☐ Yes ☑ No

If yes, give details below:

State or government agency	Date	Reason for denial	REQ	REC
			☐	☐
			☐	☐

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

☐ Yes ☑ No

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

State	Date	Reason for surrender	REQ	REC
			☐	☐
			☐	☐

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

☐ Yes ☑ No

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

Name of facility	Address and zip	Date	Reason for action	REQ	REC
				☐	☐
				☐	☐

20. Have you ever received a deferred prosecution, a deferred judgement, been convicted of, or pled guilty, or **nolo contendere** to a violation of any federal, state, or local law. Please respond "yes" if any charged are currently pending.

☐ Yes ☑ No

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

Date	Court address and zip	Violation	Penalty or disposition	REQ	REC
				☐	☐
				☐	☐

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

☐ Yes ☑ No

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

Date	Court address and zip	Violation	Penalty or disposition	REQ	REC
				☐	☐
				☐	☐

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

REDACTED

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

REQ ☐ REC ☐

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

REDACTED

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

REQ ☐ REC ☐

L1C

Office use only

LICENSE DATA (continued)

24. Within the last five years, has any final judgement, 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 enclosed Claims Information Form.

Date	Name and address of Insurance Company	Reason For Action	REQ	REC
			☐	☐
			☐	☐
			☐	☐
			☐	☐

25. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been cancelled or rated at a higher premium due to past claims experience? If yes, explain on a separate sheet and provide verification of same from insurance company or state licensing board.

☐ Yes ☑ No

REQ ☐ REC ☐

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

INS ☑

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

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

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

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

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

E Aron
Signature

4/13/99
Date

L1D

BOARD OF MEDICAL EXAMINERS

APR 26 1999

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690 V/TDD (303) 894-2900 ext. 833
FAX: (303) 894-7692

CERTIFICATE OF MEDICAL EDUCATION

THIS SECTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO SCHOOL WHERE MEDICAL DEGREE WAS RECEIVED

This certifies that ELISABETH A. ARON
FULL NAME OF APPLICANT

of 1925 Eastchester Road Apt 2C Bronx, NY 10461
ADDRESS WHEN ENROLLED

enrolled in ALBERT EINSTEIN COLLEGE OF MEDICINE
FULL NAME OF MEDICAL SCHOOL

1300 Morris Park Ave Bronx, NY on the 29th day of August ,19 88
LOCATION OF MEDICAL SCHOOL

THIS SECTION TO BE COMPLETED BY PRESIDENT/SECRETARY/DEAN OF MEDICAL SCHOOL AND FORWARDED TO COLORADO BOARD OF MEDICAL EXAMINERS. COMPLETE ALL BLANKS IN THE SECTION OR FORM WILL BE RETURNED.

The undersigned certifies that the records of this institution show that ~~he~~/she attended this institution beginning on the 29th day of August ,19 88, and was granted the degree ~~Bachelor~~/Doctor of Medicine ~~or Doctor of Osteopathy~~ on the 3rd day of June ,1992

Signed and the college seal affixed
this 20th day of April ,19 99.
By Mrs. Lillian Lomberdi, Registrar

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:

IF NO SCHOOL SEAL, PLEASE INDICATE ABOVE NEXT TO SIGNATURE OF PRESIDENT/SECRETARY/DEAN.

L2

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations
BOARD OF MEDICAL EXAMINERS
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BOARD OF MEDICAL EXAMINERS
APR 27 1999
STATE OF COLORADO

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

TO BE COMPLETED BY THE FACILITY FOR EVERY MEDICAL/OSTEOPATHIC SCHOOL GRADUATE COMPLETING POSTGRADUATE TRAINING IN THE UNITED STATE OR CANADA. PLEASE TYPE OR PRINT.

This certifies that ELISABETH A. ARON
FULL NAME OF APPLICANT

a graduate of ALBERT EINSTEIN COLLEGE OF MEDICINE
FULL NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in ST. LUKE'S / ROOSEVELT HOSPITAL
NAME AND ADDRESS OF FACILITY
1000 Tenth Avenue # 10001
New York, NY 10019

on July 1 19 92, and satisfactorily completes such training

on June 30 19 96. This training consisted of 48 months of actual clinical instruction and is approved by the Accredited Council for Graduate Medical Education (ACGME), the American Osteopathic association (AOA), or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

List type and length of training.

ROTATION OB/GYN residency 4 years LENGTH OF ROTATION 4 years

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

REDACTED

IF NO, PLEASE ATTACH AN EXPLANATION.

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

NAME Veronica Gomez-Lobo MD

ADDRESS 1000 Tenth Ave
NY NY 10019

PHONE NUMBER (212) 523-3348

DATE 4-22-99

SIGNATURE [signature] MD

L3

Dr. Audrey Buxbaum
Downtown Women OB/GYN
568 Broadway
Suite 304
New York, NY 10012

212-966-7600

April 13, 1999

Licensing Section
Colorado Board of Medical examiners

To whom it may concern,

I am writing this letter on behalf of Elisabeth Aron who is applying for a Colorado Medical license.

Dr. Aron has worked with me from July 1996 to the present time. Her last month with me will be June 1999. This is an OB/GYN private practice. She has hospital privileges at Beth Israel Medical Center.

REDACTED

Sincerely,

Audrey Buxbaum

BOARD OF MEDICAL EXAMINERS

STATE OF COLORADO

Department of Regulatory Agencies
Division Of Registration

APR 2 6 1999

STATE OF COLORADO

SEE INSTRUCTIONS ON REVERSE

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

REPORT OF PRACTICE HISTORY
ORIGINAL LICENSURE

Facility Name	Address and Zip	Reference (name & title)	Dates of Practice From – To (MO/YR – MO/YR)	Nature of Practice
St. Luke's/ Roosevelt N. 1. Hospital	1000 Tenth Ave New York, NY 10019	DR. ROBERT NEWIRTH	7/92 - 6/96	OB/GYN residency program
Downtown Women 2. OB/GYN	568 Broadway Suite 304 NY NY 10012	DR. ANDREW BUXBAUM, MD	7/96 – present	Private practice OB/GYN
Beth Israel medical 3. Center	1st Ave and 16th st NY NY 10003	DR. DANIEL SALTZMAN	7/96 – present	Hospital Affiliation
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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

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

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

L6

SIGNATURE

ARON
PRINT LAST NAME

4/13/99
DATE

INSTRUCTIONS FOR COMPLETION OF THE REPORT OF PRACTICE HISTORY - L6 FOR ORIGINAL LICENSURE

1. **LIST ALL OF YOUR EXPERIENCE IN MEDICAL PRACTICE IN CHRONOLOGICAL ORDER SINCE MEDICAL SCHOOL including:**
   1. all internships, residency, and fellowships programs,
   2. clinic practice,
   3. private practice,
   4. any other medical practice or position,
   5. any hospital that you held privileges at during the last five years, including temporary privileges and consulting privileges,
   6. any locum tenens positions, and
   7. if you have not practiced medicine for a one month or greater

2. **REQUEST AN ORIGINAL LETTER OF VERIFICATION COVERING THE LAST FIVE YEARS FOR THE ABOVE:**

   Each letter should be addressed to "Licensing Section, Colorado Board of Medical Examiners."

   Each letter verifying hospital privilages should be written by the chief of staff or chief administrative officer.

   Each letter verifying private practice, should be written by an associate or colleague.

   If contracted by a locum tenens agency, one letter from that agency verifying all positions held will suffice.

   Each letter must verify dates of practice (include beginning month and year and ending month and year), nature of practice, and privilege status.

   Each letter must also include an evaluation of your skill level, aptitude, ability to apply knowledge, and an assessment of your attitude and behavior toward your colleagues and patients.

   For Training Programs: Form L3 must be used to verify the first year of internship/post graduate training, however, a letter or Form L3 may be used to verify training programs after the first year.

   * Note: If you have not practiced medicine for more than two years immediately preceding the filing of this application, contact the Board for a copy of the "Continued Competence" rules.

Elisabeth Aron, MD
235 West 75th Street
Apartment 12G
New York, NY 10023
212-579-5097

April 13, 1999

Board Of Medical Examiners
State of Colorado

To whom it may concern,

I am applying for a Colorado medical license. I do not have malpractice coverage in Colorado at this time because I currently reside outside of Colorado. I therefore claim exemption number 3. I understand that before I engage in any medical practice in Colorado, I must obtain the required insurance or an acceptable equivalent.

Sincerely,

Elisabeth Aron

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CERTIFICATION & VERIFICATION UNIT
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

BOARD OF MEDICAL EXAMINERS

JUN 14 1999

STATE OF COLORADO

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, ARON ELISABETH A
WAS ISSUED LICENSE/CERTIFICATE NUMBER 198226 FOR THE PRACTICE OF MEDICINE ON 01/17/95.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: REDACTED
SCHOOL ATTENDED: ALBERT EINSTEIN MED COL
DATE OF GRADUATION: 06/03/92
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:
B NATIONAL BOARD CERTIFICATE #421438 DATED 07/01/93

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: YES REG PERIOD ENDS: 12/31/00
ADDRESS: APT 12 G 235 WEST 75 ST
NEW YORK NY 10023-0000
DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I FRANK GEBOSKY, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

Frank Gebosky 06/02/99
PRINCIPAL CLERK

OP026 055

BETH ISRAEL MEDICAL CENTER
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

FIRST AVENUE AT 16TH STREET
NEW YORK, NEW YORK 10003
PHONE (212) 420 - 2948
FAX (212) 420 - 2980

DANIEL H. SALTZMAN, M.D.
CHIEF, OBSTETRICS
DIRECTOR, MATERNAL - FETAL MEDICINE

ASSOCIATE PROFESSOR
OF OBSTETRICS AND
GYNECOLOGY
ALBERT EINSTEIN COLLEGE
OF MEDICINE

April 19, 1999

Licensing Section
Colorado Board of
Medical Examiners

To whom it may concern:

I am writing this letter on behalf of Elisabeth Aron who is applying for a Colorado Medical License.

Dr. Aron has had hospital privileges from July, 1996 to the present time.

Sincerely,

Daniel H. Saltzman, MD
Acting Chairman
Department of OB/GYN

COLORADO BOARD OF MEDICAL EXAMINERS
2001 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #	LICENSE #
ARON	ELISABETH	A	REDACTED	37973

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

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

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

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

RECEIVED
APR 26 2001
BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 DEA registration? ☐ YES ☑ NO

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

HAVE YOU PREVIOUSLY REPORTED ANY OF THE ABOVE MATTERS TO THE BOARD? REDACTED
IF YES, PROVIDE DOCUMENTATION IN SUPPORT OF YOUR RESPONSE. IF APPLICABLE, PROVIDE A COPY OF THE FINAL DISPOSITION FROM THE BOARD.

2001 LICENSE RENEWAL QUESTIONNAIRE AND INSURANCE VERIFICATION FORM

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

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

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

  ☐ COPIC ☐ Doctors Company ☐ St Paul ☐ Other (Specify)_____

  NOTE Please supply your insurance policy number _____

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

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

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

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

MAKE CHECKS PAYABLE TO: COLORADO BOARD OF MEDICAL EXAMINERS

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

[signature] 4/18/01

Signature of Physician **Date**

ELISABETH A. ARON 37973

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

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

Renewal - DR.0037973

Name	Elisabeth A Aron
Credential	DR.0037973

Fee Details

Renewal Fee	$2.00
Renewal Fee	$334.00
Renewal Fee	$3.00
Renewal Fee	$18.00
Renewal Fee	$144.00
	$501.00

DR Renewal Questionnaire

PART I: MANDATORY RENEWAL QUESTIONNAIRE

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

Mail all documentation to:

Colorado Medical Board, ATTN: Renewal, 1560 Broadway, Suite 1350, Denver, CO 80202

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

1. Have you been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any health care facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law, whether involuntary or in lieu of investigation?

No

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

If you answer YES to question number 2, you must provide a detailed summary of the events which led to the charges or citation. Include a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.

No

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

If you answer YES to question number 3, you must provide a copy of the notification from the insurance carrier and a summary of the events which led to the action by the carrier. If you do not have a copy of the notification, contact the insurance carrier to obtain one.

No

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

If you answer YES to question number 4, you must provide a detailed summary of the events which led to the charges or citation. Include a copy of the charges or citation, intake and discharge summary (if applicable), and all communication with (and from) the citing agency and the court of jurisdiction.

No

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

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

If you answer YES to questions 5, you must provide a detailed summary to the Board of the conduct/allegation upon which action was taken.

No

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

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

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

No

SECTION B IN THE LAST TWO YEARS:

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

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

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

R

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

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

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

R

PART 2: MANDATORY ATTESTATION

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

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

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

Please select only 1 item below.

D. I maintain commercial professional liability insurance with a company other than those listed in A, B, or C above that is authorized to do business in Colorado, in minimum indemnity amounts of at least $1,000,000 per incident and $3,000,000 annual aggregate per year. Please submit an e-mail with the name of that company to **DORA_MedicalBoard@state.co.us**.

KEEP A COPY OF YOUR COMPLETED FORM FOR YOUR RECORDS

DR Renewal HPPP

Healthcare Professions Profiling Program ACTIVE status only:

Healthcare Professions Profile Program (HPPP): All Active status licensees must maintain their Healthcare Professions Profile with current information. This profile must be updated within 30 days of any change or reportable event.

After you have completed and paid for you renewal please visit www.dora.colorado.gov/professions/hppp if you need to review and/or update your Profile. Please note: The Profile database is a separate system from our renewal system and uses a different login and password than the ones you used to renew your license.

If you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profile Program (HPPP) at: dora_dpo_hppp@state.co.us or (303) 894-5942.

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.0037973

Name	Elisabeth A Aron
Credential	DR.0037973

Fee Details

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

Affidavit of Eligibility - Screening Present

AFFIDAVIT OF ELIGIBILITY

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

Affidavit of Eligibility - Screening Doc Change

AFFIDAVIT OF ELIGIBILITY

2. Are you a United States Citizen and the State or Federally issued document, in which you proved your legal status in the United States is still valid **and** has not expired since you last completed an Affidavit of 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.0037973

Name	Elisabeth A Aron
Credential	DR.0037973

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
4567 East 9th Avenue	Denver	Colorado	80220	(303) 320-2484
330 East Laurel Street	Fort Collins	Colorado	80524	(970) 448-4940

HPPP - MEDICAL Education and Training

Education and Training

51. School or Education Level:
Albert Einstein College of Medicine of Yeshiva Uni

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

1992

HPPP GLOBAL - Other Licenses

Other Licenses

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

HPPP GLOBAL - Other Licenses if Yes

Other Licenses

54. Other Licenses:

State	License Status	Year Originally Issued
New York	Expired	1994

HPPP GLOBAL - Board Certifications

Board Certifications

55. Do you hold any current Board Certifications?
Yes

HPPP - MEDICAL Board Certifications if Yes

Board Certifications

56. Board Certifications:

Certification

Obstetrics and Gynecology

HPPP GLOBAL - Practice Specialties

Practice Specialties

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

HPPP - MEDICAL Practice Specialties if Yes

Practice Specialties

58. Practice Specialties:

Specialty
Obstetrics and Gynecology

HPPP GLOBAL - CO Hospital Affiliations

Colorado Hospital Affiliations

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

HPPP GLOBAL - CO Hospital Affiliations if Yes

Colorado Hospital Affiliations

60. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
Rose Medical Center	Other	Denver

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
Centennial High School Health Clinic	Other	Fort Collins	Colorado

HPPP GLOBAL - Business Ownership

Business Ownership

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

HPPP GLOBAL - Employer

Employer

65. Do you have an employer in the profession in which you are licensed or are applying for a license?
No

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:
I am the Medical Director of the Centennial High School in school clinic. This is a volunteer (unpaid) position. 2014 Resident Education award.

HPPP GLOBAL - Attestation

Attestation

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

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

87. Submission Date:
03/20/2017

Review

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

Renewal - DR.0037973

Name	Elisabeth A Aron
Credential	DR.0037973

Fee Details

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

DR Renewal Attestation

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

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

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

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

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

By renewing my license in ACTIVE status, I attest that I have NOT had any inquiry, investigation or administrative/judicial proceeding by the followingfollowing OR that I have reported, or will report this information within 30 days to the Colorado Medical Board at dora_medicalboard@state.co.us or 303-894-7690.:

- A licensing authority
- A government agency
- An employer
- An educational institution
- A professional organization
- In connection with an employment disciplinary or termination procedure

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

All statuses click Next to proceed.

PDMP Renewal Attestation

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

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

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

Click Next to proceed.

AoE Renewal Update

Affidavit of Eligibility | Renewal Update of Information

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

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

No

AoE Attestation

Affidavit of Eligibility | Section C: Attestation

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

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

96. Please enter today's date below:

03/14/2019

Healthcare Profile - Physician Introduction

Healthcare Professions Profile | Introduction

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

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

Healthcare Profile - Location of Practice

Healthcare Professions Profile | Location of Practice

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

Yes

Healthcare Profile - Location of Practice if Yes

Healthcare Professions Profile | Location of Practice

98. Practice Locations:

Address	City	State	Zip Code	Phone Number
4567 East 9th Avenue	Denver	Colorado	80220	(303) 320-2121
825 Shields Street	Fort Collins	Colorado	80521	(970) 493-0281
1024 South Lemay Avenue	Fort Collins	Colorado	80524	(970) 495-7000
330 East Laurel Street	Fort Collins	Colorado	80524	(970) 488-4940

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

99. School or Education Level:
Albert Einstein College of Medicine of Yeshiva Uni

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

1992

Healthcare Profile - Other Licenses

Healthcare Professions Profile | Other Licenses

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

Healthcare Profile - Other Licenses if Yes

Healthcare Professions Profile | Other Licenses

102. Other Licenses:

State	License Status	Year Originally Issued
New York	Expired	1994

Healthcare Profile - Board Certifications

Healthcare Professions Profile | Board Certifications

103. Do you hold any current Board Certifications?
Yes

Healthcare Profile - Medical Board Certifications if Yes

Healthcare Professions Profile | Board Certifications

104. Board Certifications:

Certification

Obstetrics and Gynecology

Healthcare Profile - Practice Specialties

Healthcare Professions Profile | Practice Specialties

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

Healthcare Profile - Medical Practice Specialties if Yes

Healthcare Professions Profile | Practice Specialties

106. Practice Specialties:

Specialty
Obstetrics and Gynecology

Healthcare Profile - Colorado Hospital Affiliations

Healthcare Professions Profile | Colorado Hospital Affiliations

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

Healthcare Profile - Colorado Hospital Affiliations if Yes

Healthcare Professions Profile | Colorado Hospital Affiliations

108. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
Rose Medical Center	Admitting Privileges	Denver
Poudre Valley Hospital	Admitting Privileges	Fort Collins

Healthcare Profile - Other Facility and Out of State Hospital Affiliations

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

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

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

Healthcare Professions Profile | Other State Hospital Affiliations

110. Other Healthcare Facility Affiliations:

Facility	Affiliation Type	City	State
PPRM	Other	Fort Collins	Colorado

Healthcare Profile - Business Ownership

Healthcare Professions Profile | Business Ownership

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

Healthcare Profile - Employer

Healthcare Professions Profile | Employer

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

Healthcare Profile - Employer if Yes

Healthcare Professions Profile | Employer

114. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
Questcare/Em Care	12221 Merit Drive Suite 1500	Dallas	Texas	75251	(800) 369-8397

Healthcare Profile - Employment Contracts

Healthcare Professions Profile | Employment Contracts

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

Healthcare Profile - Disciplinary Actions

Healthcare Professions Profile | Disciplinary Actions

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

Healthcare Profile - Restrictions and Suspensions

Healthcare Professions Profile | Restrictions and Suspensions

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

Healthcare Profile - Healthcare Facility Actions

Healthcare Professions Profile | Healthcare Facility Actions

121. Since September 1, 1990, have you had any final actions resulting in involuntary limitations or probationary status on or reduction, nonrenewal, denial, revocation or suspension of medical staff membership or clinical privileges at a hospital or healthcare facility? You are not required to report a precautionary or administrative suspension unless you resigned your medical staff membership or clinical privileges while the suspension was pending.

Yes

Healthcare Profile - Healthcare Facility Actions if Yes

Healthcare Professions Profile | Healthcare Facility Actions

122. Healthcare Facility Actions:

Facility Name	City	State	Type of Action	Year of Action	Duration	Terms Complete
Poudre Valley Hospital	Fort Collins	Colorado	Denial	2019	indefinitely	Yes

Healthcare Profile - Termination of Employment

Healthcare Professions Profile | Termination of Employment

123. Have you ever been terminated by an employer for a reason that would be considered a violation of your profession's practice law?

No

Healthcare Profile - DEA Registration

Healthcare Professions Profile | DEA Registration

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

No

Healthcare Profile - Convictions

Healthcare Professions Profile | Convictions

128. Since you were issued a license to practice your profession in any state or country, have you had any final criminal conviction(s) or plea arrangement(s) resulting from the commission or alleged commission of a felony or crime of moral turpitude in any jurisdiction?

No

Healthcare Profile - Malpractice Claims

Healthcare Professions Profile | Malpractice Claims

130. Since September 1, 1990, have you had any final judgment, entered into a settlement, or paid an arbitration award for malpractice?

Yes

Healthcare Profile - Malpractice Claims if Yes

Healthcare Professions Profile | Malpractice Claims

131. Malpractice Claims:

Year	State	Claim Type	Arbitrator, Mediator or Court
2015	Colorado	Judgement	Petition for Writ of Certiorari DENIED

Healthcare Profile - Malpractice Carrier Refusal

Healthcare Professions Profile | Malpractice Carrier Refusal

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

No

Healthcare Profile - Optional Narrative

Healthcare Professions Profile | Optional Narrative

134. Optional Narrative:

2012: Masters in Public Health from the Colorado School of Public Health 2017-present: Volunteer co-medical Director of Centennial HS Clinic 2014: Resident Education Award

Healthcare Profile - Attestation

Healthcare Professions Profile | Attestation

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

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

135. Submission Date:

03/14/2019

Review

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

Renewal - DR.0037973

Name	Elisabeth A Aron
Credential	DR.0037973

Fee Details

DR - Legal Defense Fund	$2.00
DR - PDMP Fee	$14.00
DR - Portal Fee	$2.00
DR - Renewal Fee Active	$238.00
DR- Peer Fee	$140.00
	$396.00

DR_CDRH Renewal Attestations

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

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

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

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

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

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

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

By renewing my license in ACTIVE status, I attest that: I have established and will continuously maintain professional liability insurance as required by statute.

All statuses click Next to proceed.

DR & CDRH Peer Health Provider Compliance

If you have been formally evaluated by the designated peer health provider and are in compliance with all requirements, you can attest to this renewal. 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 peer health provider at no cost to address any health concerns, including psychosocial matters such as burnout and family problems.

The peer assistance program is dedicated to improving the health and wellness of licensed medical professionals in a confidential manner.

Participation in the 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.

Medical Substance Use Prevention Training Attestation

Attestation for ACTIVE status Renewal: I attest that by renewing my Colorado license in an Active status, I meet the state Board's substance use prevention training requirements by one of the following methods:

I have completed at least two (2) hours of training since my last renewal in order to demonstrate competency regarding the following topics/areas:

- Best practices for opioid prescribing according to the most recent version of the Division's guidelines for the safe prescribing and dispensing of opioids.
- Recognition of substance use disorders.
- Referral of patients with substance use disorders for treatment.
- The use of the electronic prescription drug monitoring program.

OR

I am exempt from the substance use prevention training requirement for one of the following reasons:

- I maintain a national board certification that requires equivalent substance use prevention training.
- I attest that I do not prescribe opioids.

I attest that I have means to prove completion of my substance use prevention training requirements and I am aware that DORA reserves the right to review this documentation. I will provide this information IF REQUESTED through a renewal audit by the Division of Professions and Occupations.

All statuses select Next to proceed.

PDMP Renewal Attestation

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

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

If you have questions about registering or to check if you have registered, please contact Appriss' 24/7 support line at (855) 263-6403 or email the Colorado PDMP Administrator at pdmpinqr@state.co.us for assistance.

Click Next to proceed.

*Affidavit of Eligibility Lawful Presence

Affidavit of Eligibility | Section A: Lawful Presence

1. 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

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

*Affidavit of Eligibility Documents

Affidavit of Eligibility | Section B: Verification Documents

3. 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.

Colorado Drivers License or Identification Card

4. 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

5. 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:

03/31/2021

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

6. 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

7. Practice Locations:

Address	City	State	Zip Code	Phone Number
4567 East 9th Avenue	Denver	Colorado	80220	(303) 320-2484
330 East Laurel Street	Fort Collins	Colorado	80524	(970) 488-4940
825 Shields Street	Fort Collins	Colorado	80521	(970) 493-0281

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

8. School or Education Level:
Albert Einstein College of Medicine of Yeshiva Uni

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

1992

Healthcare Profile - Other Licenses

Healthcare Professions Profile | Other Licenses

10. 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

11. Other Licenses:

State	License Status	Year Originally Issued
New York	Expired	1994

Healthcare Profile - Board Certifications

Healthcare Professions Profile | Board Certifications

12. Do you hold any current Board Certifications?
Yes

Healthcare Profile - Medical Board Certifications if Yes

Healthcare Professions Profile | Board Certifications

13. Board Certifications:

Certification

Obstetrics and Gynecology

Healthcare Profile - Practice Specialties

Healthcare Professions Profile | Practice Specialties

14. 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

15. Practice Specialties:

Specialty
Obstetrics and Gynecology

Healthcare Profile - Colorado Hospital Affiliations

Healthcare Professions Profile | Colorado Hospital Affiliations

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

Healthcare Profile - Colorado Hospital Affiliations if Yes

Healthcare Professions Profile | Colorado Hospital Affiliations

17. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
Rose Medical Center	Other	Denver
Rose Medical Center	Admitting Privileges	Denver

Healthcare Profile - Other Facility and Out of State Hospital Affiliations

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

18. 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

19. Other Healthcare Facility Affiliations:

Facility	Affiliation Type	City	State
Centennial High School Health Clinic	Other	Fort Collins	Colorado
PPRM	Other	Fort Collins	Colorado

Healthcare Profile - Business Ownership

Healthcare Professions Profile | Business Ownership

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

Healthcare Profile - Employer

Healthcare Professions Profile | Employer

22. 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

23. Employer:

Employer Name	Address	City	State	Zip Code	Phone Number
Questcare/Em Care	12221 Merit Drive Suite 1500	Dallas	Texas	75251	(800) 369-8397
PPRM	7155 E 38th Ave	Denver	Colorado	80207	(303) 321-2458

Healthcare Profile - Employment Contracts

Healthcare Professions Profile | Employment Contracts

24. 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

26. 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

28. 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

30. 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

32. 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

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

No

Healthcare Profile - Convictions

Healthcare Professions Profile | Convictions

37. 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

39. 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

41. 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

43. Optional Narrative:
2012: Masters in Public Health from the Colorado School of Public Health 2017-present: Volunteer co-medical Director of Centennial HS Clinic 2014: Resident Education Award 2020: Resident Education Award

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.

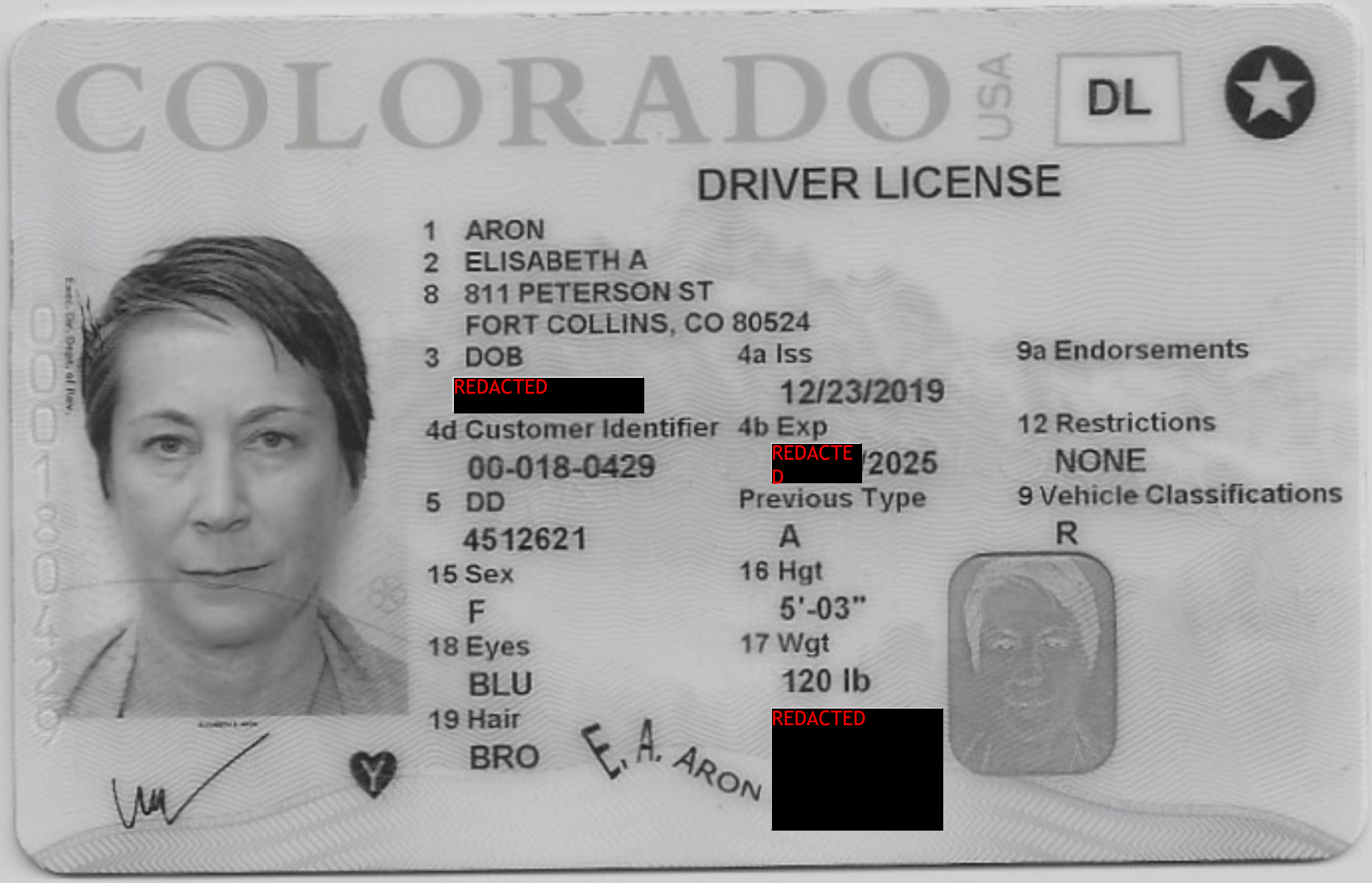
44. Submission Date:
03/31/2021

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.


COLORADO
USA
DL
DRIVER LICENSE
1 ARON
2 ELISABETH A
8 811 PETERSON ST
FORT COLLINS, CO 80524
3 DOB
REDACTED
4a Iss
12/23/2019
9a Endorsements
4d Customer Identifier
00-018-0429
4b Exp
REDACTED
/2025
12 Restrictions
NONE
5 DD
4512621
Previous Type
A
9 Vehicle Classifications
R
15 Sex
F
16 Hgt
5'-03"
18 Eyes
BLU
17 Wgt
120 lb
19 Hair
BRO
E. A. ARON
REDACTED

Interstate Medical Licensure Compact
A faster pathway to medical licensure

Application for Expedited Licensure

I have read and understood the Qualifications to practice medicine in the Compact states. I attest that I am qualified and understand that pursuant to the IMLCC's rules, all fees are non-refundable. **Yes**

If you have questions please call your State of Principle License

I understand that inaccurate or missing information may be grounds for rejection of my application.

Please carefully review the Application documents before applying. **Yes**

I have reviewed the criteria to select a State of Principal License (SPL) and confirm eligibility to designate a Compact state as my SPL. **Yes**

I have a full and unrestricted license in a Compact State **Yes**

SPL **COLORADO MEDICAL BOARD** License # **37973**

AND at least one of the below must APPLY (Please select all that apply)

a. Your primary residence is in the SPL (State of Principal License)	Yes
b. At least 25% of your practice of medicine occurs in the SPL	Yes
c. Your employer is located in the SPL	Yes
d. You use the SPL as your state of residence for U.S. federal income tax purposes	Yes

Please provide below information:

Residence Street address **811 Peterson Street**

Residence City State Zip **Fort Colllins**, **COLORADO**, **80524** **US**

Please describe your practice and location in the SPL selected **Staff physician for Planned Parenthood of the Rocky Mountains, Denver and Fort Collins, CO**
Hospitalist for Rose Medical Center, Denver CO (employed through EmCare)

Please be prepared to provide documentation to the designated SPL for further verification. If you have any question please contact your SPL.

You or your employer may be asked for additional documentation about your Employment.

Name of Employer **PPRM** Employer Contact Phone **(303) 321 - 2458**

Employer Street address **7155 E 38th Ave**

Employer City State Zip **Denver**, **COLORADO**, **80207**

Please provide your Tax ID # (SS#, EIN) REDACTED (must be most recent return)Please be prepared to provide documentation to the designated SPL for further verification.

Interstate Medical Licensure Compact
A faster pathway to medical licensure

Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes

Medical School **Albert Einstein College of Medicine** Date of Degree Issued **6/1/1992** Medical Degree Received: M.D.

Have you passed each component or step of the USMLE, or the COMLEX-USA within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes (if in question contact your SPL)? RE

Which licensing exam REDACTED **NBME**

Have you successfully completed graduate medical education approved by the ACGME or the AOA? Yes

Residency Program **St. Lukes/Roosevelt Medical Center** Completion Date **6/1/1996**

What is the specialty of the program **OB/GYN**

Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? (Board eligibility does not qualify) Yes

Name of Specialty Board Certification **American Board of Obstetrics and Gynecology**

Lifetime **No** If not lifetime, Expiration Date **12/31/2022**

Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? No

Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? No

Have you ever had a controlled substance license or permit suspended or revoked by a state or

the United States Drug Enforcement Administration? No

Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? No

Interstate Medical Licensure Compact
A faster pathway to medical licensure

PHYSICIAN'S CORE DATA SHEET

(*Must be the **physician's** accurate information to avoid delay or rejection*)

Full Legal Name __**Elisabeth** _, __**A** _, _**Aron** _, __

Other names used (maiden, birth) ____, __, __

Residential address__**811 Peterson Street** __, _**Fort Collins** __, _**COLORADO** __, _**80524**_

Office address _**7155 E 38th Ave** _, _**Denver** _, _**COLORADO** _, _**80207**_

Where do you wish to receive mail. Residential

Physician's cellular or alternative telephone number _**(970) 412 - 8088** _

Physician's office or practice telephone number of public record _**(303) 321 - 2458**_

Date of Birth REDACTED Gender: Female

Applicants personal email address _REDACTED __

Email address delegated by applicant to receive correspondence __REDACTED ___

Social Security Number: REDACTED

Physician's National Provider Identifier Number _**1386747244**_

Interstate Medical Licensure Compact
A faster pathway to medical licensure

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR AN IMLC LETTER OF QUALIFICATION AND MEDICAL LICENSES IN IMLC MEMBER STATES

I, Elisabeth A Aron (full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof, furnished or to be furnished with respect to my application, are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as potential prosecution under appropriate federal and state laws.

I hereby apply to **COLORADO MEDICAL BOARD** (state) as my State of Principal License ("SPL") for a Letter of Qualification ("LOQ") to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I authorize and request every person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, to furnish to the SPL any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the SPL, or any of its agents or representatives, to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact.

I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, of any and all liability of every nature and kind, arising out of an investigation made by the SPL.

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application. Additionally, I further authorize the SPL to process and release my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind, arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application, if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a LOQ, revocation, or other disciplinary sanctions of my license(s) or permit(s) to practice medicine, in one or more Compact Member States.

Applicant Signature Elisabeth A Aron

Type Applicant's Name Elisabeth A Aron
Applicant's NPI 1386747244
Date 9/13/2021

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

Designation of the State of Principal Licensure

This is NOT an application for licensure. Complete the form and send to the address at the bottom of this page. You may be asked to provide proof of residency.

CO DR License Number: 37973 License Expiration Date: 04/30/2023

SECTION 1- LICENSEE INFORMATION

Name: First: ELISABETH	Middle: A	Last: ARON	Suffix:
Previous Name(s):			
Social Security Number: *	REDACTED		
E-mail Address: REDACTED ***(This will be the primary communication method)***			
Mailing Address: *This is a Home ☒ Business ☐*	PO Box, Street: 811 Peterson St City, State, Zip: Fort Collins, CO 80524		

SECTION 2 –DECLARATION OF PRIMARY STATE OF RESIDENCE

"Principal State of Licensure" is defined as:

(1) The state of primary residence for the physician, or;
(2) The state where at least 25% of the practice of medicine occurs, or;
(3) The location of the physician's employer, or;
(4) If no state qualifies under the above, the state designated as the state of residence for the purpose of federal income tax.

Select ONE of the following methods:

☒ **(1) Colorado is my state of primary residence.**

Physical Address: 811 Peterson St
City: Fort Collins State: CO Zip: 80524
(PO Boxes are not accepted)

➢ **Please include a copy of your Colorado state driver's license.**

☐ **(2) Colorado is the state where at least 25% of the practice of medicine occurs:**

- **Please complete the table below for a minimum of 12 months.**

MONTH/YEAR	NAME OF LOCATION	TOTAL NUMBER OF DAYS WORKED IN MONTH	TOTAL NUMBER OF DAYS WORKED IN COLORADO
		TOTAL:	TOTAL:

☐ **(3) Colorado is the location of my employer:**

Name of Employer:_____

Physical Address:_____

City:_____ State:_____ Zip:_____

(PO Boxes are not accepted)

☐ **(4) Colorado is the state designated for purposes of federal income tax:**

I, _____ (print name), declare that no state qualifies under method (1), (2), and (3) as described on this form and 24-60-3602, Section 4(a), C.R.S., as a state of principal licensure and that Colorado is my state of primary residence for the purposes of Federal income tax.

ATTESTATION

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

Applicant Signature	**Date** 09/13/2021

ST · LUKE'S – ROOSEVELT · HOSPITAL · CENTER

IN · THE · CITY · OF · NEW · YORK

THE · ROOSEVELT · HOSPITAL
ST. · LUKE'S · HOSPITAL
WOMAN'S · HOSPITAL

BE · IT · KNOWN · BY · THESE · PRESENTS · THAT

ELISABETH · A · ARON · M·D

HAS · SERVED · UPON · THE · HOUSE · STAFF · OF · ST · LUKE'S - ROOSEVELT · HOSPITAL · CENTER
IN · THE · CAPACITY · OF

RESIDENT · IN · OBSTETRICS · AND · GYNECOLOGY

FOR · THE · PERIOD
JULY · 1 · 1992 · TO · JUNE · 30 · 1996

AND · HAS · FULFILLED · THE · REQUIREMENTS · OF · PROFESSIONAL · STUDY · AND · PRACTICE PERTAINING · TO · THIS · APPOINTMENT · AND · IS · BELIEVED · TO · POSSESS · ETHICAL AND · SCIENTIFIC · IDEALS · WORTHY · OF · THE · PROFESSION · AND · MERITING · THE · APPROVAL OF · THIS · HOSPITAL

IN · WITNESS · WHEREOF · WE · HAVE · SIGNED · THIS · DIPLOMA · AND · AFFIXED THE · SEAL · OF · THE · HOSPITAL · ON · THIS · THE · 19TH · DAY · OF · MARCH IN · THE · YEAR · OF · OUR · LORD · ONE · THOUSAND · NINE · HUNDRED · AND · NINETY - NINE

Lawrence S. Huntington
CHAIRMAN OF THE BOARD OF TRUSTEES

Richard P. Fried, M.D.
PRESIDENT OF MEDICAL BOARD

Ronald C. Ablow M.D.
PRESIDENT

Robert Lewis M.D.
DIRECTOR OF SERVICE

QUALIFICATIONS APPLICATION

If you do not complete the application process you will be sent an email with a link to log back in to complete the documents. Be sure to look in your SPAM and JUNK folders. To apply for a Letter of Qualification for licensure through the Interstate Medical Licensure Compact please answer the questions below.

IS THIS A RE-APPLICATION(earned an LOQ in the past and now is reapplying)? YES **NO** X

1. Which IMLC Member State do you want to serve as your State of Principal License (SPL)?: COLORADO

2. Do you hold a full and unrestricted medical license to engage issued by a medical licensing board in the SPL (SPL Board) COLORADO MEDICAL BOARD? Yes X No

3. What is the license number issued to you by the SPL board? DR 0053477

4. Which of the following apply to you(at least one must apply)?

a. Your primary residence is in the SPL COLORADO: Yes X No

If yes, provide the following:

Residence Street address 27 south oneida court

Residence City State Zip denver (City), CO (St), 80230 (Zip)

b. At least 25% of your practice of medicine occurs in the SPL COLORADO Yes X No

If yes, describe your current practice Hospital based practice

UC HEALTH

c. Your employer is located in the SPL COLORADO: Yes X No

If Yes, Employer name UC Health

Employer street address 12605 East 16th avenue

Employer City State Zip Aurora (City), CO (St), 80045 (Zip)

d. You have designated the SPL COLORADO as your state of residence for U.S. federal income tax purposes: Yes X No

If yes, give Tax ID # (SS#, EIN) REDACTED (must be most recent return)

5. Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes x No

6. Have you passed each component of the United State Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes(if in question contact your SPL)? REDACTED

7. Have you successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association? Yes x No

8. Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? Yes x No

---

(Please note that answering any of the following questions with a "YES" will result in your application being denied per eligibility Rule 5.4. If eligibility is in question please contact the state board directly for information regarding application through the traditional method.)

9. Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? Yes No x

10. Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? Yes No x

11. Have you ever had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? Yes No x

12. Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? Yes No x

Physician's Signature: DocuSigned by: EE3EC4CF37A544F...

Type Name: elizabeth schacht

Date: 9/28/2018 | 11:27 CDT

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR AN IMLC LETTER OF QUALIFICATION AND MEDICAL LICENSES IN IMLC MEMBER STATES

I, Elizabeth Schacht (Type in full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as my being prosecuted under appropriate federal and state laws.

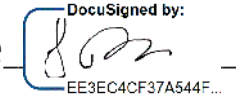
I hereby apply to COLORADO as my State of Principal License ("SPL") for a Letter of Qualification ("LOQ") to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I hereby authorize and request every person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the SPL any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the SPL or any of its agents or representatives to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact.

I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the SPL.

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application, and further authorize the SPL to process my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a Letter of Qualification, and revocation, or other disciplinary sanction, of my license(s) or permit(s) to practice medicine in one or more Compact Member States.

Applicant Signature 

Type Applicant's Name Elizabeth Schacht

Applicant's NPI 1154523884

DATE 9/28/2018 | 11:27 CDT

PHYSICIAN'S CORE DATA SHEET

(*Must be the physician's accurate information to avoid delay or rejection*)

Full Legal Name elizabeth, none, schacht, _____
(Exactly as on DL or Passport) First Middle Last Suffix(Sr., Jr.)

Other names used(maiden, birth) _____ _____ _____
First Middle Last

Mailing address 27 south oneida coury, denver, co, 80230
Mailing address City State(XX) Zip

Office address 130 rampart way, suite 100, denver, co, 80230
Office address City State(XX) Zip

Date of Birth REDACTED
(mm/dd/yyyy) Gender: Male Female X

Physician's office or practice telephone number of public record 7203086475
(###-###-####)

Physician's cellular or alternative telephone number 7203086475
(###-###-####)

Email address delegated by applicant to receive correspondence REDACTED

Social Security Number: REDACTED
(###-##-####)

Physician's National Provider Identifier Number 1154523884

Medical Degree Received: M.D. x D.O.

(Medical school must be accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or be listed in the International Medical Education Directory or its equivalent.)

Medical School Pontificia universidad javeriana
Name of School (no abbreviations or acronyms)

Date of Degree Issued 12/08/2002
(mm/dd/yyyy)

Physicians must have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. (NOTE: One-year transitional residencies do not meet this requirement)

Residency Program Jackson memorial hospital Completion Date 06/30/2010
Full Program Name (no abbreviations or acronyms) (mm/dd/yyyy)

What is the specialty of the program Anesthesiology

Qualifying Licensing exam taken: USMLE X COMLEX Other _____
Must specify by name

REDACTED USMLE:

Step 1: 1 Step 2 CS: 1 Step 2 CK: 1 Step 3: 1

REDACTED COMLEX:

Step 1: ____ Step 2 PE: ____ Step 2 CE: ____ Step 3: ____

REDACTED other licensing exam:

Step 1: ____ Step 2: ____ Step 3: ____

Specialty Board Certification must be by an ABMS or AOABOS board.

Specialty Board Certification: Anesthesiology
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

Lifetime:

Time limited: X Expiration date of time limited 12/31/2021
(mm/dd/yyyy)

Physicians must possess a full and unrestricted medical license issued by an IMLC Member Board.

License # DR 0053477 Date of Original Licensure 05/01/2015 (not renewal)
(mm/dd/yyyy)

Expiration Date 4/30/2019 Status of License: Current: Not Current: X
(mm/dd/yyyy)

Thank you for applying through the Interstate Medical Licensure Compact.

The state will contact you to give instructions on obtaining your fingerprints for a criminal background check. ***YOU HAVE 60 DAYS TO COMPLY WITH REQUESTS FROM THE STATE*** *to avoid automatic withdraw. Background checks may take some time, so please be patient. If you have any concerns contact your SPL. SPL contact numbers can be found at www.IMLCC.org. You will receive an email regarding the status of your qualification. Be sure to check your spam folder and set your email to accept messages from the @docusign.net and @docusign.com domains.*

FOR USE OF STATE OF PRINCIPAL LICENSE

I have conducted the verification process of this physician's application.

State Authorized Signature_____

Warning: The signature tab will default to your Board's name. Please change it to your name in Adopt and Sign.

Type Name_____

Title_____

CORE DATA CORRECTION SHEET

To process corrections please use the below freeform text boxes. The corrections will be passed to the Member Boards selected to issue licenses. If you use this sheet there is no need to send any correction emails.

Core Data to be changed	Incorrect data	Correction

Letter of Qualification

IS THIS A RE-APPLICATION? YES NO

Date _____
mm/dd/yyyy

Name: _____

Address: _____

_____

CityStZip _____

Dear Dr. _____:

RE: Your application for IMLC Letter of Qualification

The COLORADO MEDICAL BOARD
("Board"), on behalf of the State of Principal Licensure ("SPL") you selected, has received and reviewed your application for a Letter of Qualification ("LOQ") for licensure through the Interstate Medical Licensure Compact ("IMLC").

Based upon the information you submitted with your application, data in the Board's files regarding your licensure by the Board, verifications of your credentials, and the results of the check of national databases, the Board has determined that you are ELIGIBLE to be licensed through the IMLC. Therefore, this notice will serve as your LOQ for licensure in IMLC Member States through the IMLC, and will remain in effect for 365 days from date of issuance, set out above.

An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license in by each.

All medical licenses issued by Member Boards through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions including, but not limited to, each Member Board's continuing medical education requirements. It is also your obligation to keep your SPL, the Member Boards which have licensed you, and the IMLC Commission informed of any changes in your contact information or qualifications and eligibility for licensure through the IMLC.

Authorized Signature from SPL _____

Type Name _____

Title of Authorized SPL_____

DATE_____

CREDENTIAL STATUS HISTORY SUMMARY

Name: Elisabeth A Aron **Date:** 2/24/2022
License: Physician DR.0037973
License Status: Transferred to Compact Physician
License Status Reason: TRANSFERRED TO COMPACT PHYSICIAN
First Issuance date: 07/22/1999
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
Transferred to Compact Physician	TRANSFERRED TO COMPACT PHYSICIAN	10/18/2021	Automated
Active	CURRENT	03/31/2021	Automated
Active in Renewal	ACTIVE	03/29/2021	Automated
Active	CURRENT	03/14/2019	Automated
Active in Renewal	ACTIVE	03/12/2019	Automated
Active	CURRENT	03/20/2017	Automated
Active in Renewal	ACTIVE	03/17/2017	Automated
Active	CURRENT	03/27/2015	Automated
Approved	READY TO PRINT	03/27/2015	Automated
Active in Renewal	ACTIVE	03/17/2015	Automated
Active	CURRENT	04/04/2013	Automated
Approved	READY TO PRINT	04/04/2013	Automated
Active in Renewal	ACTIVE	03/18/2013	Automated
Active	CURRENT	06/01/2011	