APD 8512

COLORADO STATE BOARD OF MEDICAL EXAMINERS

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE **FEE $425.00**

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.**

1 a. Name: Last	First	Middle	Degree	1b. Social Security Number
MARENGO-BARBICK	Antoinette	MARIA	MD	REDACTED

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

3. Mailing Address: Number and Street/Rural Route, Apartment Number (NOTE, Address provided is, by law, public information.)
☑ Home ☐ Business 8621 E. YALE AVE #B

City DENVER State CO Zip 80231 Country USA

e-mail address: REDACTED

4. Telephone Number: (Area Code) Day (303) 266 1515 Evening (303) 752 0015

5. Date of Birth: Mo/Day/Year REDACTED Place of Birth Toledo, OHIO

6. Sex Male (Female)

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

8. List name/address of the school where 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)	Period of Attendance To (Mo/Yr)
Northwestern University Medical	303 E Superior Ave - Morton 9/d. Chicago, IL 60611	8/1996	6/2000

9. List name of licensing exam(s): ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam. Request certification of scores from examining agency be sent directly to this office.

Exam	Location	Date	Result
USMLE I	Chicago, IL	Jul 1998	REDACTED
USMLE II	Chicago, IL	Aug 1999	
USMLE III	Greenwood Village, CO	DEC 2001	

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

Name of facility	Specialty	Period of attendance From (Mo/Yr)	Period of attendance To (Mo/Yr)
Univ. of Colorado Health Sciences	OB/GYN	6/2000	PRESENT

Official Use Only	License # 40677	Date 04/26/02
Revised 10/99	Fee $ 425	Date: 4-5-02

L1A

11. Are you now or have you ever been licensed to practice medicine in any state, territory, district or country? Include temporary licenses and educational permits. Request verification from each to be sent to the Colorado Board.

☐ **Yes** If yes, provide information below.

☒ **No**

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

12. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic board of any complaint, investigation or inquiry, which is **currently pending?**

☐ **Yes** If yes, give details below.

☒ **No**

State	Date	Charge	Disposition

13. Has **any disciplinary action** ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity? (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question.

☐ **Yes** If yes, give details below.

☒ **No**

State	Date	Charge	Disposition

14. Have you ever entered into any agreement with any state, territory, district, country, US government agency, and state medical/osteopathic board regarding your medical license?

☐ **Yes** If yes, give details below:

☒ **No**

Agency	Date	Reason

15. 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 US federal jurisdiction?

☐ **Yes** If yes, give details below:

☒ **No**

Agency	Date	Reason for denial

16. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in any state country or U.S. federal jurisdiction? This does not include allowing your license to lapse solely due to non-payment of the renewal fee.

☐ **Yes** If yes, explain on a separate sheet, summarize below:

☒ **No**

Agency	Date	Reason

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

☐ **Yes** If yes, explain on a separate sheet, provide copy of resignation letter or hospital action and summarize below:

☒ **No**

Name of facility	Date	Reason for action

18. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law? Note: You *must respond "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is* unnecessary to report traffic offenses that do not involve alcohol or drugs.

☐ **Yes** If yes, explain on a separate sheet. Summarize details below:

☒ **No**

Date	Court	Violation	Penalty or disposition

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

RED ACT ED **Yes** 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.

No

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

RED ACT ED **Yes** 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.

No

21. Within the last five years, have you been diagnosed or treated for bipolar disorder, severe major depression, schizophrenia or other psychotic disorder?

RED ACT ED **Yes** If yes, explain on a separate sheet. Be specific as to date of occurrences, the type of disorder involved, and what if anything has been done to treat the disorder.

No

22. Within the last five years, has any final judgment, settlement or arbitration award for medical malpractice been paid on your behalf or has any claim been filed which is still pending?

☐ **Yes** If yes, list below and complete the enclosed Claims Information Form.

☒ **No**

Date	Name and address of Insurance Company	Reason for Action

23. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been canceled or rated at a higher premium due to past claims experience?

☐ **Yes,** If yes, explain on a separate sheet and provide verification from insurance company or state licensing board.

☒ **No**

24. You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado Law, or claim one of the four 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 the exemption claimed below.

EXEMPTION CLAIMED: _____

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, Antoinette MARIA MARENGO-BARBICK 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.

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, as defined in 18-8-503, C.R.S., that the information contained 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 and that application fees are not refundable.

Antoinette M. Marengo-Barbick
Signature

3/18/2002
Date

RETURN THIS APPLICATION TO:

COLORADO BOARD OF MEDICAL EXAMINERS
1560 BROADWAY, SUITE 1300
DENVER CO 80202-5140

L1D

STATE OF COLORADO

STATE BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5146
(303) 894-7715/894-7716
FAX (303) 894-7692
V/TDD (303)894-7880
http://www.dora.state.co.us/medical

Department of Regulatory Agencies
Division of Registrations

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Antoinette MARIA MARENGO-BARBICIC
FULL NAME OF APPLICANT

enrolled in Northwestern University Medical School
FULL NAME OF MEDICAL SCHOOL

Chicago, IL on the 30 day of August 1996
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 30 day of August, 1996 and was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy on the 02 day of June, 2000.

Signed and the college seal affixed

This 02 day of May, 2002

By Mary Rachuy, Program Assistant 2 Mary Rachuy

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

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BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

Department of Regulatory Agencies
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CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

THIS SECTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO THE FACILITY WHERE POSTGRADUATE TRAINING WAS RECEIVED AND/OR COMPLETED

This certifies that Antoinette MARIA MARENCO-BARBICK
FULL NAME OF APPLICANT

a graduate of Northwestern University Medical School
FULL NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in University of Colorado Health Sciences Center
NAME AND ADDRESS OF FACILITY

TO BE COMPLETED BY THE PROGRAM DIRECTOR OF THE FACILITY FOR ACGME/AOA POSTGRADUATE TRAINING IN THE UNITED STATE OR CANADA. PLEASE TYPE OR PRINT.

on June 22, 2000 and satisfactorily completes such training on June 30, 2004.

This training ~~consisted~~ will consist 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 Training for 4 yrs. LENGTH OF ROTATION:

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.

PROGRAM DIRECTOR Kirsten J. Lund, MD

ADDRESS Univ of Colo HSC - Dept of Ob/Gyn, 4200 E. 9th Ave, B198, Denver, CO 80262

PHONE NUMBER (303) 315-3169 DATE 3/27/02

SIGNATURE X

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STATE OF COLORADO

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BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

REPORT OF PRACTICE HISTORY

Facility Name	Address and Zip	Reference (name and title)	Dates of Practice From-To	Nature of Practice
L3 1. University of Colorado Health Sciences Center	4200 E 9th Avenue #B198 Denver, CO 80262		June 23, 2000 - present	OB/Gyn Residency
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

PLEASE BE AWARE 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 Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

Antoinette Marengo-Barbick, MD — MARENGO-BARBICK — 3/25/02 — **L6**

SIGNATURE — PRINT LAST NAME — DATE

INSTRUCTIONS FOR COMPLETION OF THE REPORT OF PRACTICE HISTORY (L6)

1. LIST ALL OF YOUR EXPERIENCE IN MEDICAL PRACTICE IN CHRONOLOGICAL ORDER SINCE MEDICAL SCHOOL, including

- All internships, residency and fellowship programs,
- Clinic practice,
- Private practice,
- Any other medical practice or position,
- Any hospital that you held privileges at during the last five years, including temporary privileges and consulting privileges,
- Any locum tenens positions, and
- Breaks in the practice of medicine of 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 privileges 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 (including 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 Program: 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, refer to the Continued Competency Rule included in this package.

Graduate Medical Education
School of Medicine
4200 East Ninth Avenue, C293
Denver, Colorado 80262
Phone: 303-315-7424
Fax: 303-315-7399

CONFIRMATION OF MALPRACTICE COVERAGE

The University of Colorado provides medical malpractice coverage to its students, interns, residents and other health care practitioners-in-training at the Health Sciences Center through a Self-Insurance Trust fund (the "Trust") authorized and established pursuant to a resolution of the Regents of the University of Colorado. This coverage extends to these individuals while they are duly enrolled at the University and is subject to the terms of the Trust's Coverage Document.

As employees of the University, all such persons are "public employees," and therefore their liability in any medical malpractice action is limited by the Colorado Governmental Immunity Act (C.R.S. § 24-10-114) as follows:

(a) for any injury to one person in any single occurrence, the sum of $150,000;
(b) for any injury to two or more persons in any single occurrence, the sum of $600,000 except in such instance, no person may recover in excess of $150,000.

These are also the limits of the Trust's coverage.

The coverage provided applies to the individual identified above while he/she is in any activity or program which has received the prior approval of the University of Colorado Health Sciences Center, regardless of where such activity or program may take place. The Health Sciences Center will not provide professional liability coverage for any activities engaged in at your hospital if the physician receives compensation for those activities other than through the Health Sciences Center. In addition, under the Colorado Governmental Immunity Act, the limits on liability, and hence the Health Sciences Center's professional liability coverage, do not apply to willful and wanton acts.

For those approved activities that take place in a state other than Colorado or for activities which a court of competent jurisdiction determines on final judgment that the limits of the Colorado Governmental Immunity Act do not apply, the Trust has provided for coverage of $5,000,000/$5,000,000 through a commercial insurance policy issued to the University.

All inquiries regarding the coverage provided or claims history for the individual named below should be directed to the Office of Professional Risk Management, 4200 E. 9th Ave., A-039, Denver, Colorado 80262.

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

Today's Date:	June 10, 2002	Date program began:	June 23, 2000
Houseofficer's name:	Antoinette Marengo Barbick, MD	Date program ends:	June 30, 2003

STATE OF COLORADO

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Department of Regulatory Agencies
Division of Registrations

DISCIPLINARY ACTION REPORT

PLEASE COMPLETE ALL BLANKS ON THIS FORM AND MAIL TO:

FEDERATION OF STATE MEDICAL BOARDS
400 Fuller Wiser Road
Suite 300
Euless, TX 76039-3855

Phone: 817-868-4000
Fax: 817-868-4099

*****NO FEE REQUIRED*****

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

APR 0 1 2002

DALE L. AUSTIN
DEPUTY EXECUTIVE VICE PRESIDENT
AND CHIEF OPERATING OFFICER

The Federation of State Medical Boards maintains a national databank of all disciplinary action taken by state licensing boards and/or other credentialing agencies. To complete your application we must have a report from the Federation. Please note: an unfavorable report does not automatically disqualify you from licensure in Colorado.

NAME Antoinette MARIA MARENGO-BARBICK
ADDRESS 8621 E. YALE AVE #B
CITY, STATE AND ZIP CODE DENVER, CO 80231
DATE OF BIRTH REDACTED
SOCIAL SECURITY NUMBER
MEDICAL SCHOOL Northwestern University Medical School
DATE OF GRADUATION June 2, 2000

I hereby authorize and request that the Federation of State Medical Boards of the United States Inc. provide a disciplinary history to the State of Colorado Board of Medical Examiners

Antoinette M. Marengo-Barbick, MD 3/18/02
Signature Date

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