MEDICAL DOCTOR
APPLICATION FOR LICENSURE 1501
Apply for your license online at www.flboardofmedicine.gov

Choose your application type: F-137906

03/29/2018 800.00
ID: 137906 Type: F
BT: 3015243
R#: 917031597

☑ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months qualify for a waiver of the application fee and the initial licensure fee. In order to c above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☑ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: CADWALLADER (Last/Surname) KARA (First) LANE (Middle) **Date of Birth:** 07/10/1967 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

1019 NORTH 9TH STREET (Street/ PO Box) _____ (Suite/Apt. No) BOISE (City)

IDAHO (State) 83702 (Zip) _____ (Country) 208-369-0862 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

2001 EAST MADISON STREET (Street/ P.O. Box) _____ (Suite/Apt. No) SEATTLE (City)

WA (State) 98122 (Zip) _____ (Country) 208-367-6042 (Alternate Phone Number)

Email Address: sdeckelman-klinke@statmedcaresolutions.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male ☑ Female **RACE:** ☑ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other

☐ Yes ☑ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

9. HEALTH HISTORY

If you answer "Yes" to any of the questions in this section, you are required to send the following items:

- A self-explanation providing accurate details that include name of all physicians, therapists, counselors, hospitals, institutions, and/or clinics where you received treatment and dates of treatment.
- A report directed to the Florida Board of Medicine from each treatment provider about your treatment, medications, and dates of treatment. If applicable, include all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).

[redacted]

In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the past five years?

Name: CADWALLADER (**Last**) KARA (**First**) LANE (**Middle**)

Social Security Number: [redacted]

Social Security Information - * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L. Section 317) Clarification of the SSA process may be reviewed at **www.ssa.gov** or by calling 1-800-772-1213.

STATMedCare
Solutions, LLC

03/26/2018

Florida Board of Medicine
PO Box 6330
Tallahassee, FL 32314-6330

To whom it may concern:

Please find enclosed the application for Kara Cadwallader, MD and a cashier's check for $800 (application fee $350, initial license fee $350 and $100 for dispensing fee).

She has given me the authorization to handle all communications directly with the Board of Medicine. I have enclosed the authorization form.

The copy of her NPDB and all requested verifications will be sent to you from the primary source.

Please contact me with any discrepancies or questions you might have.

Sincerely,

Sonja Deckelman-Klinke, CPCS, CPMSM
Provider Enrollment Specialist III
Cell: 706-414-9706
Fax: 706-432-1020
Email: sdeckelman-klinke@statmedcaresolutions.com

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☐ Yes ☑ No Are you using the FCVS to verify your core credentials?

☑ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
UNIVERSITY OF CALIFORNIA SCHOOL OF MEDICINE, SAN FRANCISCO, CA	06/1991	06/1995	JUNE 11, 1995

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☑ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☑ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
TACOMA FAMILY MEDICINE INTERNSHIP/RESIDENCY	FAMILY PRACTICE	6/1995	6/1998	Y
UNIVERSITY OF WASHINGTON FELLOWSHIP	FAMILY MEDICINE	7/03	6/04	Y

Loan History:

☐ Yes ☑ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXA INATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: USMLE ID: 4-002-847-4 Date passed: 05/01/1996
mm/dd/yy

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☑ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
IDAHO	PHYSICIAN	M-8268
WASHINGTON	PHYSICIAN	MD00035453
ALASKA	PHYSICIAN	MEDS7717
CALIFORNIA (INACTIVE)	PHYSICIAN	68695
HAWAII	PHYSICIAN	18189

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☑ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☑ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☑ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 1997 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☐ Yes ☑ No Have you practiced medicine in another jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☑ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
PLANNED PARENTHOOD OF THE GREAT NW 2001 East Madison Street Seattle, WA 98122	SENIOR MEDICAL DIRECTOR	11/12	PRESENT

☑ Yes ☐ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
ST. LUKE'S BOISE MEDICAL CENTER
PLANNED PARENTHOOD GREAT NW & HI ISLANDS
FAMILY MEDICINE RESIDENCY OF IDAHO, BOISE ID

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☑ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☑ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

☑ Yes ☐ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)
AMERICAN BOARD OF FAMILY MEDICINE	FAMILY MEDICINE	04/2015

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☑ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☑ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☑ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

☑ Yes ☐ No I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. ILITARY HISTORY

A. ☐ Yes ☑ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☑ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☑ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☑ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☑ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☑ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☑ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☒3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☐8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/11/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307 109210-PL ON-PROVI-18-19 SEA,W PL	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED PLANNED PARENTHOOD OF THE GREAT NORTHWEST AND THE HAWAIIAN ISLANDS, AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 2001 E. MADISON ST. SEATTLE, WA 98122	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** National Union Fire Ins. Co. of Pittsburgh, PA — 19445 **INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** NYC-009739161-24 **REVISION NUMBER:** 7

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☐ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT ☐ LOC OTHER:						EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $ $ $ $ $
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	UMBRELLA LIAB ☐ OCCUR **EXCESS LIAB** ☐ CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N/A **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below						☐ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
A	MEDICAL PROFESSIONAL CLAIMS-MADE COVERAGE			6793286 'Program Retro Date: 11/1/76'	01/01/2018	01/01/2019	EACH WRONGFUL ACT AGGREGATE	$1,000,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

KARA CADWALLADER, MD IS AN INSURED UNDER THIS POLICY.

CERTIFICATE HOLDER

KARA CADWALLADER, MD
C/O PLANNED PARENTHOOD OF THE GREAT NORTHWEST AND THE HAWAIIAN ISLANDS
2001 E. MADISON ST.
SEATTLE, WA 98122

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE of Marsh USA Inc.

Ricki Fitzsimmons

BOARD OF MEDICINE
Financial Responsibility Affidavit of Exemption N/A

This affidavit is only required if you are claiming an Exemption based on number 9 on the preceding page.

I,_____, do hereby certify and attest that I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5) (f), F.S., for specific notice requirements.

Dated: _____ Signature:_____

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this_____day of_____, by

_____

_____
(Signature of Notary Public - State of Florida)

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known_____OR Produced Identification _____

Type of Identification Produced_____

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION N/A

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☐	☐	
$5,000	$250	$0	
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Name

Signature Date

Street Address

City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

KARA L. CADWALLADER, MD

Print name

Signature

3.20.18

Date

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS N/A

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.039(1)(b) F. S. You must submit a completed form for each occurrence. If you are an allopathic, osteopathic, or podiatric physician, to satisfy this reporting requirement you may submit copies of reports previously submitted under the requirements of s. 456.049 F. S. instead of this exhibit.

Date of occurrence: / /____ Date reported to licensee: / /____ Date claim reported to insurer or self-insurer / /_____

Injured person's name: (last, first, middle initial)_____

Street Address:_____

City:_____ State:_____ Zip Code: _____
Age:_____ Sex: _____

Date of suit, if filed: / /____

List all defendants with their health care provider license number involved in this claim:
1 _____ 2._____
3._____ 4._____

Date of final claim disposition:_____/_____/_____

Date and amount of judgment or settlement, if any: _____

Was there an itemized verdict? [ ] Yes [ ] No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $_____
Loss adjustment expense paid to defense counsel: $_____
All other loss adjustment expense paid: $_____

The date and reason for final disposition, if no judgment or settlement: _____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

[ ] Patient's Room
[ ] Operating Suite
[ ] Recovery Room
[ ] Physical Therapy Dept.
[ ] Nursery
[ ] Critical Care Unit
[ ] Radiology
[ ] Emergency Room
[ ] Other
[ ] Labor & Delivery Room
[ ] Special Procedure Room

Final diagnosis for which treatment was sought or rendered: _____

Describe misdiagnosis made, if any, of the patient's actual condition. _____

Describe the operation, diagnostic, or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration. _____

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable. _____

Safety management steps taken by the licensee to make similar occurrences less likely: _____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that providing any false statements made in writing with the intent to mislead the Department staff in the performance of their official duties, shall be punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of physician: _____

AUTHORIZATION FOR THIRD PARTY CONTACT

Provider Name: Kara Lane Cadwallader, MD

Phone Number: 208-367-6042

SSN: [redacted] Date of Birth: 07/10/1957

Email: kara.cadwallader@ppgnhi.org

I, Kara L. Cadwallader, hereby authorize the following person/business to communicate with the licensing board regarding my application for initial licensure. I understand that information received from the person or business listed below shall be binding and that I will be responsible for the accuracy of all information and documents received as part of my application for initial licensure. This authorization shall expire upon issuance of the license, referral to enforcement or expiration of the application.

Name of authorized representative: Sonja Deckelman-Klinke
Phone: 706-414-9706
Email: sdeckelman-klinke@statmedcaresolutions.com

Applicant Signature

3.20.18
Date

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Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

FLORIDA DEPARTMENT OF HEALTH

CONFIRMATION OF SUBMISSION

NAME:	**KARA LANE CADWALLADER**
PROFESSION:	**MEDICAL DOCTOR**
LICENSE NUMBER:	**ME136691**
RECEIPT DATE:	12/23/2019
FEE PAID:	$465.00
APPLICATION NUMBER:	911366
MAILING ADDRESS:	1019 NORTH 9TH STREET BOISE, ID 83702
ATTENTION:	
PRACTICE ADDRESS:	2001 EAST MADISON STREET SEATTLE, WA 98122
ATTENTION:	

NOTE:
This document confirms receipt of an application and fee for the above-named practitioner. Confirmation of your renewal can be viewed by visiting http://www.FLHealthsource.gov and selecting "Verify A License". If additional information is needed you will receive a separate request. If you do not receive your license or a request for additional information within 30 days, please contact us at (850) 488-0595.

Florida Department of Health
Division of Medical Quality Assurance
4052 Bald Cypress Way
Tallahassee, FL 32399-3260

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

FLORIDA DEPARTMENT OF HEALTH

CONFIRMATION OF SUBMISSION

NAME:	**DR KARA LANE CADWALLADER**
PROFESSION:	**MEDICAL DOCTOR**
LICENSE NUMBER:	**ME136691**
RECEIPT DATE:	01/25/2022
FEE PAID:	$455.00
APPLICATION NUMBER:	1195612
MAILING ADDRESS:	1019 NORTH 9TH STREET BOISE, ID 83702
ATTENTION:	
PRACTICE ADDRESS:	2001 EAST MADISON STREET SEATTLE, WA 98122
ATTENTION:	

NOTE:
This document confirms receipt of an application and fee for the above-named practitioner. Confirmation of your renewal can be viewed by visiting http://www.FLHealthsource.gov and selecting "Verify A License". If additional information is needed you will receive a separate request. If you do not receive your license or a request for additional information within 30 days, please contact us at (850) 488-0595.

Florida Department of Health
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4052 Bald Cypress Way
Tallahassee, FL 32399-3260

Accredited Health Department
Public Health Accreditation Board

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☒	☐	
$5,000	$250	$0	Paid via cashier's check 11077928
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

KCadwallader 5/23/2018

Signature Date

Kara Cadwallader, MD
Name
1019 North 9th Street
Street Address
Boise, ID 83702
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.