License Type:	**Physician's and Surgeon's**
Application:	**Physician's and Surgeon's - Initial Application**
Application Number:	**14758219**
Application Date:	**03/22/2020 (mm/dd/yyyy)**

Application Questions

Are you currently enrolled in an ACGME/RCPSC-accredited postgraduate training program in the United States or Canada?	**No**
Are you applying with an Individual Taxpayer Identification Number (ITIN)?	[redacted]
Have you served or are you currently serving in the military?	
Are you requesting expediting of this application for spouses or domestic partners of an active duty member of the U.S. Armed Forces?	
Are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces?	
Are you requesting expediting of this application to practice in a medically underserved area or population?	**Yes**

Personal Detail

First Name:	**Krista**
Middle Name:	**Lynn**
Last Name:	**Ault**
Birthdate:	****/**/******
Gender:	**Female**
SSN/ITIN:	*************

Addresses

License Related Addresses

Address of Record

Warning: **In order to protect your privacy and identity, address will not be displayed.**

License Attributes Selected

IND 20

Previous Application or License

Have you served or are you currently serving in the U.S. Military?	[redacted]
Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the U.S. Armed Forces?	
Have you ever filed an application for a Physician's and Surgeon's License or other license in California that has been withdrawn, abandoned, or denied?	
Have you previously held a Physician and Surgeon License in California?	**No**

Examinations

Are you certified by the Educational Commission for Foreign Medical Graduates?	**No**

Examinations 1

Examination:	**United States Medical Licensing Examination (USMLE) Step 1**
Date Passed:	**05/24/2007 (mm/dd/yyyy)**

Examinations 2

Examination:	**United States Medical Licensing Examination (USMLE) Step 2CK**
Date Passed:	**09/01/2008 (mm/dd/yyyy)**

Examinations 3

Examination:	**United States Medical Licensing Examination (USMLE) Step 2CS**
Date Passed:	**10/01/2008 (mm/dd/yyyy)**

Examinations 4

Examination:	**United States Medical Licensing Examination (USMLE) Step 3**
Date Passed:	**06/04/2010 (mm/dd/yyyy)**

Medical Education

Medical School Name:	**Indiana University School of Medicine**
Mailing Address of the Medical School:	**Van Nuys Medical Science Room, 164 635 N Barnhill Dr Indianapolis, IN 46202**
Attendance Start Date:	**06/01/2005 (mm/dd/yyyy)**
Attendance End Date:	**05/01/2009 (mm/dd/yyyy)**

Title of Degree Awarded:	**MD - Doctor of M icine**
Issue Date of Degree:	**05/10/2009 (mm/dd/yyyy)**

ACGME or RCPSC Accredited Postgraduate Training Programs

Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada?	**Yes**

ACGME or RCPSC Accredited Postgraduate Training Programs

Program Facility Name:	**HealthOne/Rose Family Medicine**
City:	**Denver**
State/Province:	**Colorado**
Specialty:	**Family Medicine**
Training Start Date:	**06/01/2009 (mm/dd/yyyy)**
Training End Date:	**06/01/2012 (mm/dd/yyyy)**

ACGME or RCPSC Accredited Postgraduate Training Programs

Have you ever received partial or no credit for a postgraduate training program?	[redacted]
Have you ever taken a leave of absence or break from your training?	
Have you ever been terminated, dismissed or expelled from a program?	
Have you ever been placed on probation for any reason?	
Have you ever been disciplined or placed under investigation?	
Have you ever had any limitations or special requirements placed upon you for clinical performance professionalism, medical knowledge, discipline, or for any other reason?	
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	[redacted]

Medical License Information

Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province?	**Yes**

Medical License(s)

U.S. State, U.S. Territory or Canadian Province:	**Colorado**

Practice Start Date:	**03/30/2011 (mm/ yyyy)**

ABMS Certification

Are you currently certified by a Member Board of the American board of Medical Specialties?	**Yes**

Malpractice History

Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgement, or arbitration?	[redacted]

Disciplinary History

Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	[redacted]
Have you ever been denied a license to practice medicine or is any denial pending against you?	
Have you ever had any license to practice medicine subjected to any disciplinary action or is any disciplinary action pending against any of your licenses to practice medicine?	
Have you ever surrendered a license to practice medicine or have you ever had any license to practice medicine revoked, suspended, or placed on probation?	
Have you ever had any license to practice medicine subjected to any action including, but not limited to, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	[redacted]
Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?	
Have you ever resigned from a medical staff in lieu of disciplinary or administrative action or is any disciplinary action pending against your hospital or staff privileges?	
Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	

or certificate disciplined by a[illegible] her state or federal territory?

Practice Impairment or Limitations

Are you currently enrolled in, or participating in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?

Do you currently have any condition (including, but not limited to emotional, mental, neurological or other physical, addictive, or behavioral disorder) that impairs your ability to practice medicine safely?

Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?

Criminal Record History

Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in the United States, its territories, or a foreign country?

Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357 (b), (c), (d), (e), or section 11360 (b) which are two years or older, have you had a conviction that was set aside or later expunged from the record of the court?

Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?

Are you a registered Sex Offender?

Family Physician Training Program Voluntary Fee

Would you like to contribute?

Attachments

Fees

Application Fee	**$442.00**
Department of Justice (DOJ) Fee	**$32.00**
Federal Bureau of Investigation (FBI) Fee	**$17.00**
Initial License Fee	**$783.00**

Total Amount Due: $1299.00

Applications are not considered submitted for processing until payment is received.

Attestation

I attest I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto is a sufficient basis for denying or revoking a license.

Signature: Date:

GR #2050910

MBC USE ONLY

PHOTOGRAPH AND NOTICE

[redacted]

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act.

Reviewed L1A-L1F

Staff Initials & Date 4/24/19

Photo

DECLARATION

Full Legal Name (First, Middle, Last, Suffix) | Date of Birth (mm/dd/yyyy)

The applicant, Krista Lynn Ault, [redacted], being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; and that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

Applicant Name & DOB

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION, OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Applicant Signature & Date

SIGN LEGAL NAME: [signature] **DATE:** 4/18/20

NOTARY SECTION

Applicant Signature

SIGNATURE OF APPLICANT: [signature]

(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Colorado County of La Plata

Applicant Name & Notary Date

Subscribed and sworn to (or affirmed) before me on this 18 day of April, 2020.

Print Applicant's Legal Name

by, Krista Lynn Ault

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

(NOTARY SEAL)

STERLING KYLE FARNSWORTH
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20184031897
MY COMMISSION EXPIRES 08/09/2022

Notary Signature & Seal

[signature]

SIGNATURE OF NOTARY PUBLIC

Form L1F

Medical Board of California

Certificate of Completion of ACGME/RCPSC/CFPC Postgraduate Training

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

MBC USE ONLY

APPLICANT INFORMATION

Check One: ☑ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate** Applicant Information ✓

Legal Name

Full Last Name	First Name	Middle Name	Suffix
Ault	Krista	L.	

Date Of Birth (mm/dd/yyyy)	U.S. SSN or ITIN (Last 4 digits)	Medical School of Graduation
[redacted]	[redacted]	Indiana University School of Medicine

PROGRAM DIRECTOR TO COMPLETE ACGME, RCPSC, or CFPC TRAINING INFORMATION

Facility Name	University of Colorado Family Medicine Residency at Rose Medical Center	Verified Program Information ✓
Facility Address	Program has Closed - Address was: 4545 E. 9th Ave, Suite 010 Denver, CO 80220	
Specialty	Required: Family Medicine	
ACGME 10-digit Program# https://apps.acgme.org/ads/Public	Required: 1200721071	✓
Dates of Training	Start Date (mm/dd/yyyy): 06/23/2009 — End Date (or anticipated completion date): (mm/dd/yyyy): 06/30/2012	✓✓

UNUSUAL CIRCUMSTANCES

Program Director: Provide a signed and dated letter of explanation, including dates, for any "yes" response to questions # 1-7. The explanation must be provided on program letterhead and mailed directly to the Board with this form.

1. Did the applicant receive partial or no credit during postgraduate training?	[redacted] Yes	[redacted] No ✓
2. Did the applicant ever take a leave of absence or break from training?	[redacted] Yes	[redacted] No ✓
3. Was the applicant ever terminated, dismissed, or expelled?	[redacted] Yes	[redacted] No ✓
4. Was the applicant ever placed on probation?	[redacted] Yes	[redacted] No ✓
5. Was the applicant ever disciplined or placed under investigation?	[redacted] Yes	[redacted] No ✓
6. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	[redacted] Yes	[redacted] No ✓
7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?	[redacted] Yes	[redacted] No ✓

GENERAL MEDICINE TRAINING REQUIREMENT

Applicants must complete and receive credit for at **least four (4) months** of general medicine as part of their postgraduate training. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.

8. Did the applicant complete and received credit for a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC? ☑ Yes ☐ No

Gen Med Required ✓

Form PTA

APPLICANT INFORMATION

Legal Name

Full Last Name	First Name	Middle Name	Suffix
Ault	Krista	L.	

MBC USE ONLY
Applicant Name

ATTENTION: PROGRAM DIRECTOR

Do not sign and date this form prior to the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the applicant has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Only the program director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months. The person who signs this form may not be related to the applicant by blood, marriage, or adoption.

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the particular postgraduate level and that the applicant satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms is true and correct. I further certify that the training program is accredited by the ACGME, RCPSC, or CFPC to offer the type and level of training completed by the applicant named on this form, and the applicant was trained in an ACGME, RCPSC, or CFPC slotted program position.

Verified PD Staff Initials & Date

Kenton I Voorhees, MD
PRINTED NAME OF PROGRAM DIRECTOR

Program Director's Signature & Date

Kenton I. Voorhees MD — 03/23/2020
SIGNATURE OF PROGRAM DIRECTOR — **DATE**

Note: If a program seal is not available, the program director shall also sign in the section below in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: Kenton I. Voorhees MD
(SIGN FULL NAME IN PRESENCE OF NOTARY)

Program Director's Signature

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Colorado County of Denver

Subscribed and sworn to (or affirmed) before me on this 26th day of May, 2020,

Print Program Director's Name

by, Kenton Voorhees MD

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

Lisa P Martinez
SIGNATURE OF NOTARY PUBLIC

(PROGRAM or NOTARY SEAL)

Notary Signature & Seal

Program Seal

LISA P MARTINEZ
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20014012173
MY COMMISSION EXPIRES MAY 06, 2021

Note: The completed forms must be submitted directly from the program to the Board to be acceptable.

Form PTB

Lookup Detail View

Licensee Information

This serves as primary source verification of the license.*

**Primary source verification: License information provided by the Colorado Division of Professions and Occupations, established by 24-34-102 C.R.S.*

Name	Public Address
Krista Lynn Ault	810 E 3rd St Suite 201 Durango, CO 81301

License Information

Some Physician Licensees have converted their Active Physician license to an Active Compact Physician License. This is noted below by the status label: Transferred to Compact Physician. If this status is present, then you may verify the license by searching for the license using the prefix "CDRH" and the Licensees Name on our Online Services page (https://apps.colorado.gov/dora/licensing/Lookup/LicenseLookup.aspx).

License Number	License Method	License Type	License Status	Original Issue Date	Effective Date	Expiration Date
DR.0049867	Original	Physician	Active	03/30/2011	05/01/2019	04/30/2021

Board/Program Actions

Discipline
There is no Discipline or Board Actions on file for this credential.

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