STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations BOARD OF MEDICAL EXAMINERS

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

MAR 2 5 1999

5154

STATE OF COLORADO

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: JIBBEN; First: CELESTE; Middle: M.; Degree: MD

1b Social Security Number: [redacted]

LT

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

NPDB

3. Mailing Address — Number and Street/Rural Route, Apartment Number: 1821 W 49th St — This is my home ☐ business ☐ — parents address until I move to Greeley CO June 1999

City: MPLS — State: MN — Zip: 55409 — Country: Hennipen

e-mail address:

BC

4. Telephone Number (Area Code) Day Evening
612-925-1386 - P APR 1999
520 697 3346 - until APR 1999

5 Date of Birth. Mo/Day/Year: [redacted] — Place of Birth: Aberdeen SD USA
Submit a certified or notarized copy of your birth certificate or passport.

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)
University of Wyoming	Laramie WY 82071	8/83	4 85/88

MEDICAL EDUC

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

L2

Name of School	Address and zip	Period of attendance From (Mo/Yr)	To (Mo/Yr)
Creighton University	Omaha NE 68178	8/88	12/92

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 # 38329 Date 4/7/99
Fees Date 3/25/99

11503

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, II, III	Omaha, NE	1990, 1992, 1993	[redacted]

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)
Walter Reed Army Medical Center	Wash DC	Transitional Internship	1/93	12/93

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)
Maryland	D46967	1/6/95	Federal Employee	

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)

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:

REQ REC

State	Date	Charge	Disposition

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

REQ REC

State or government agency	Date	Charge	Disposition

L1B

OFFICE USE ONLY

LICENSE DATA (continued)

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 ☐

Office use only

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

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

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

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, Celeste Tilden, 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

C Tilden
Signature

3/15/99
Date

L1D

STATE OF COLORADO

Department of Regulatory Agencies
Division Of Registration

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
1	Walter Reed AMC	6900 Georgia Ave NW Washington DC 20307	✓ Nancy Dawson	11/93 - 12/93	transitional internship
2	WRAMC	6900 Georgia Ave NW Washington DC 20307	Joe Zelig	1/94 - 9/95	GMO for emergency department
3	Kayenta, IHS PHS	POB 368 Kayenta AZ 86033	Matt Rydzarg	9/95 - 4/99	General practitioner for Indian Health Service
4					
5					
6		BOARD OF MEDICAL EXAMINERS		BOARD OF M[illegible]	
7		MAR 2 5 1999 STATE OF COLORADO		MAY 0 5 1999	
8				STATE OF COLORADO	
9					
10					

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L6

Cjibben — SIGNATURE

JIBBEN — PRINT LAST NAME

3/15/99 — 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.

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations
BOARD OF MEDICAL EXAMINERS

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BOARD OF MEDICAL EXAMINERS

APR 0 2 1999

STATE OF COLORADO

CERTIFICATE OF MEDICAL EDUCATION

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

RECEIVED
MAR 29 1999
UNIVERSITY REGISTRAR

This certifies that Celeste Jibben
FULL NAME OF APPLICANT

of _____
ADDRESS WHEN ENROLLED

enrolled in Creighton University
FULL NAME OF MEDICAL SCHOOL

Omaha Nebraska on the _____ day of August ,1988
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 29 day of 8 ,19 88 and was granted the degree Bachelor/Doctor of Medicine or Doctor Osteopathy on the 19 day of 12 ,19 92

Signed and the college seal affixed

this 29 day of MArch ,19 99.

By JOHN A. KRECEK REGISTRAR John A. Krecek

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:

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

L2

BOARD OF MEDICAL EXAMINERS
APR 06 1999
STATE OF COLORADO

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

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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 Celeste Jibran (FULL NAME OF APPLICANT) medical school Creighton

a graduate of Walter Reed Army Medical Center Transitional Internship (FULL NAME OF MEDICAL/OSTEOPATHIC SCHOOL)

commenced postgraduate training in WRAMC (NAME AND ADDRESS OF FACILITY)

Washington DC

on Jan 19 93, and satisfactorily completes such training

on Dec 19 93 This training consisted of 12 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	LENGTH OF ROTATION
Transitional Internship	One Year

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 SUSAN L. REED, ADMIN., MEDICAL EDUCATION

ADDRESS WALTER REED ARMY MEDICAL CENTER
6825 16th Street N.W.,
Washington, D.C. 203075001

PHONE NUMBER (202) 782-7241

DATE 3/31/99

SIGNATURE Susan L. Reed

L3

STATE OF COLORADO

Department of Regulatory Agencies
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This certifies that Celeste Jibben
FULL NAME OF APPLICANT

A graduate of Creighton Medical School
FULL NAME OF MEDICAL/OSTEOPATHIC SCHOOL

Commenced postgraduate training in Walter Reed Army Medical Center
NAME AND ADDRESS OF FACILITY
Georgia Ave
Washington DC 20123

on ~~December~~ January 1 1993, and satisfactorily completes such training

on December 31 1993. This training consisted of 12 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	LENGTH OF ROTATION
Transitional Internship	12 months

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

[redacted]

IF NO, PLEASE ATTACH AN EXPLANATION.

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NAME

ADDRESS

PHONE NUMBER

DATE

SIGNATURE

L3

BOARD OF MEDICAL EXAMINERS

AUG 0 9 1999

STATE OF COLORADO

STATE OF COLORADO

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NAME AND ADDRESS OF FACILITY
Georgia Ave
Washington DC 20123

on ~~December~~ January 1 **19** 93 **, and satisfactorily completes such training**

on December 31 **19** 93 **. This training consisted of** 12 **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	LENGTH OF ROTATION
Transitional Internship	12 months

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 WALTER REED ARMY MEDICAL CENTER

ADDRESS 6825 16th Street N.W.,
Washington, D.C. 203075001

PHONE NUMBER (202) 782-7241

DATE Susan L. Reed 8/5/99

SIGNATURE SUSAN L. REED, ADMIN., MEDICAL EDUCATION

L3

STATE OF COLORADO

Department of Regulatory Agencies
Division Of Registration

SEE INSTRUCTIONS ON REVERSE

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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
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2	WRAMC		Joe Zelig	1/94 - 9/95	GMO for emergency department
3	Kayenta, IHS PHS	PO Box 368 Kayenta AZ 86033	Matt Rydberg	9/95 - 4/99	General practitioner for Indian Health Service.
4					
5					
6		BOARD OF MEDICAL EXAMINERS			
7		MAR 25 1999 STATE OF COLORADO			
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

C Jibben — SIGNATURE

JIBBEN — PRINT LAST NAME

3/15/99

CO Board of Medical Examiners
1560 Broadway Suite 1300
Denver CO 80202-5140

BOARD OF MEDICAL EXAMINERS
JUN 28 1999
STATE OF COLORADO

NEW APPLICANT

CHANGE OF ADDRESS FORM

Be sure to immediately notify the Board of any address change so that you will receive all information concerning your application. Make copies of this form for future use.

Pursuant to Colorado law the preferred mailing address of any licensee or applicant is available to the public. This address will also soon be available on the Medical Board Internet website. Thus, please carefully consider the address provided to the Board. The preferred address will also be used to mail all licenses, renewal notices and other official correspondence from the Medical Board. Your preferred mailing address may be a Post Office Box address.

If you do not indicate which address will be your preferred mailing address, the business address will constitute the preferred mailing address.

We cannot accept a change of address that requests the address be changed for some, but not all communications. Additionally, we cannot accept a change of address which requires the Board to mark correspondence as "confidential."

Entered in ARMS 7-8-99 WH

Returned my call & gave following change of information

****

New Business Address **This is my preferred mailing address.**

please continue to use N. Colorado Family Medicine as my published address. Thank you. 1600 23RD AVE Greeley Co 80631

Phone # 970-356-2424 WH **Effective Date**

✓ **New Home Address** **This is my preferred mailing address.**

2401 13TH AVE
Greeley CO 80631

Phone # 9703929242 **Effective Date** 6/23/99

Print Name Celeste Tibben **License #**

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BOARD OF MEDICAL EXAMINERS
APR 06 1999
STATE OF COLORADO

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

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on Jan 19 93, and satisfactorily completes such training

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Transitional Internship	One Year

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[redacted]

IF NO, PLEASE ATTACH AN EXPLANATION.

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NAME SUSAN L. REED, ADMIN., MEDICAL EDUCATION

ADDRESS WALTER REED ARMY MEDICAL CENTER
6825 16th Street N.W.,
Washington, D.C. 203075001

PHONE NUMBER (202) 782-7241

DATE 3/31/99

SIGNATURE Susan L. Reed

L3

7/21/99

TO ANIS BUCKNER

Dr Anis -

I would greatly appreciate it if you could fill out this form & fax it to Co Board of Med Examiners @ 303-894-7692 and to me @ 970-346-2828

Thank-you very much.

Celeste Jibben

Celeste Jibben

MARYLAND BOARD OF PHYSICIAN QUALITY ASSURANCE
P.O. Box 2571
4201 Patterson Avenue
Baltimore, MD 21215-0095
(410) 764-4777
Fax (410) 358-2252
e-mail: [redacted]

BOARD OF MEDICAL EXAMINERS
APR 12 1999
STATE OF COLORADO

April 5, 1999

Requested by COLORADO BOARD OF MEDICINE

The following is available under the Maryland Public Information Act, State Government Article, Section 10-617(h), regarding the following practitioner

JIBBEN, CELESTE MARIE
PO BOX 368
KAYENTA, AZ 86033

License Number	D0046967
Date Issued	January 06, 1995
Current Status	Active
Expiration Date	September 30, 2000
Medical School	CREIGHTON UNIV SCH OF MED
Licensed By	
Specialty	
Charges	0
Disciplinary Actions	NONE

No Maryland Health Claims Arbitration Office malpractice claims filed since July 1, 1986

Yvette McCleod
Verification Clerk
04/05/1999
Date

This is a computer generated form which is acceptable by other states
Licensing examination scores should be requested directly from the examining authority

BOARD OF MEDICAL EXAMINERS

OCT 2 2 1999

STATE OF COLORADO

STATE OF COLORADO

Department of Regulatory Agencies
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NAME AND ADDRESS OF FACILITY
Georgia Ave
Washington DC 20307

on ~~December 31~~ January 1 1993, and satisfactorily completes such training

on December 31 1993. This training consisted of 12 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	LENGTH OF ROTATION
Transitional Internship	12 months

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 WALTER REED ARMY MEDICAL CENTER

ADDRESS 6825 16th Street N.W.,
Washington, D.C. 203075001

PHONE NUMBER (202) 782-7241

DATE 10/12/99

SIGNATURE Susan L. Reed

SUSAN L. REED, ADMIN., MEDICAL EDUCATION

L3

March 22, 1999

To whom it may concern:

Please use as my published address my place of employment. I will be starting as a 2nd year resident @ the North Colorado Family Medicine Center in Greeley in July, 1999.

Celeste Jibben
North Colorado Family Medicine
1600 23rd Ave
Greeley, Colorado 80631

Thank you

C Jibben

Celeste Jibben

BOARD OF MEDICAL EXAMINERS
MAR 25 1999
STATE OF COLORADO

CERTIFICATE OF INSURANCE
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

ADDRESSEE:

COLORADO STATE BOARD OF MEDICAL EXAMINERS
LICENSING SECRETARY
1560 BROADWAY SUITE 1300
DENVER CO 80202-5140

BOARD OF MEDICAL EXAMINERS
JUL 16 1999
STATE OF COLORADO

NAME & ADDRESS OF INSURED:

CELESTE JIBBEN M D
NORTH COLORADO FAMILY MEDICINE
1600 23RD AVENUE
GREELEY CO 80631

This Certificate is issued as a matter of information only and confers no rights upon the holder. By its issuance the Company does not alter, change, modify or extend the provisions of said policy and does not waive any of its rights thereunder.

POLICY NUMBER: [redacted] **RETRO DATE:** 07-01-1999
POLICY PERIOD: 07-01-1999 **TO:** 07-01-2000

LIMITS OF LIABILITY:
Per Medical Incident: $ 1,000,000
Annual Aggregate: $ 3,000,000

SPECIALTY/CLASS: PGY2-FAMILY PRACTICE & OB/CLASS 8

CANCELLATION:
Should the above described policy be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 days written notice to the above named certificate holder, but failure to mail such notice shall impose no obligation or liability of any kind upon the company.

Dated at: Denver, Colorado **Date:** 07-15-99

Countersigned by Authorized Representative

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

RECEIVED
MAR 29 1999
By

FEDERATION OF STATE MEDICAL BOARDS
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

BOARD OF MEDICAL EXAMINERS
APR 01 1999
STATE OF COLORADO

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN
MAR 31 1999
James R Winn M.D.
JAMES R WINN M.D.
EXECUTIVE VICE PRESIDENT

NAME Celeste Tibben

ADDRESS POB 368

CITY, STATE AND ZIP CODE Kayenta AZ 86033

DATE OF BIRTH [redacted]

SOCIAL SECURITY NUMBER [redacted]

MEDICAL SCHOOL Creighton University

DATE OF GRADUATION 12/92

I hereby authorize and request that the Federation of State Medical Boards of the United States Inc provides a disciplinary history to the following

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

Signature _____ Date 3/15/99

To complete your application we must have a report form the Federation's National Databank of disciplinary actions taken by by state licensing boards and/or other credentialing agencies Please note an unfavorable report does not automatically disqualify you from licensure in Colorado

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

L7

COLORADO BOARD OF MEDICAL EXAMINERS
2001 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #	LICENSE #
JIBBEN	CELESTE		[redacted]	38297

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

RECEIVED
APR 30 2001
BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

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.

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 [redacted]

- ☐ 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

C Jibben 4/12/01

Signature of Physician **Date**

Celeste Jibben 38297

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.0038297

Name	Celeste M Jibben
Credential	DR.0038297

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.

[redacted]

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.

[redacted]

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.

H. I am a physician who provides uncompensated health care to patients, or who does not otherwise engage in any compensated patient care in Colorado.

DR Renewal HPPP

Healthcare Professions Profiling Program ACTIVE status only:

REMINDER:

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.

After you have read the above, please click the "Next" button below.

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.0038297

Name	Celeste M Jibben
Credential	DR.0038297

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.0038297

Name	Celeste M Jibben
Credential	DR.0038297

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
603 S. Dakota St.	Milbank	South Dakota	57252	

HPPP - MEDICAL Education and Training

Education and Training

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

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
Minnesota	Active	2002

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
Family Medicine

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
Family Medicine

HPPP GLOBAL - CO Hospital Affiliations

Colorado Hospital Affiliations

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

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?
No

HPPP GLOBAL - Business Ownership

Business Ownership

63. Do you have a current business ownership interest in any healthcare-related business?
Yes

HPPP GLOBAL - Business Ownership if Yes

Business Ownership

64. Business Ownership:

Business Name	City	State
Jibben, PLLC	Minneapolis	Minnesota

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:

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:
04/12/2017

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.0038297

Name	Celeste M Jibben
Credential	DR.0038297

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 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 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:

03/19/2019

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
603 S. Dakota St.	Milbank	South Dakota	57252	

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

99. School or Education Level:
Creighton University School of Medicine

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
Minnesota	Active	2002

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
Family Medicine

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
Family Medicine

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?
No

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?
No

Healthcare Profile - Business Ownership

Healthcare Professions Profile | Business Ownership

111. Do you have a current business ownership interest in any healthcare-related business?
Yes

Healthcare Profile - Business Ownership if Yes

Healthcare Professions Profile | Business Ownership

112. Business Ownership:

Business Name	City	State
Jibben, PLLC	Minneapolis	Minnesota

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?
No

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.
No

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?
No

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:

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:
03/19/2019

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.0038297

Name	Celeste M Jibben
Credential	DR.0038297

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.

Out of State 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:

04/22/2021

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
603 S. Dakota St.	Milbank	South Dakota	57252	

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

8. School or Education Level:
Creighton University School of Medicine

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
Minnesota	Active	2002

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
Family Medicine

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
Family Medicine

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?
No

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?
No

Healthcare Profile - Business Ownership

Healthcare Professions Profile | Business Ownership

20. Do you have a current business ownership interest in any healthcare-related business?
Yes

Healthcare Profile - Business Ownership if Yes

Healthcare Professions Profile | Business Ownership

21. Business Ownership:

Business Name	City	State
Jibben, PLLC	Minneapolis	Minnesota

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?
No

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:

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.

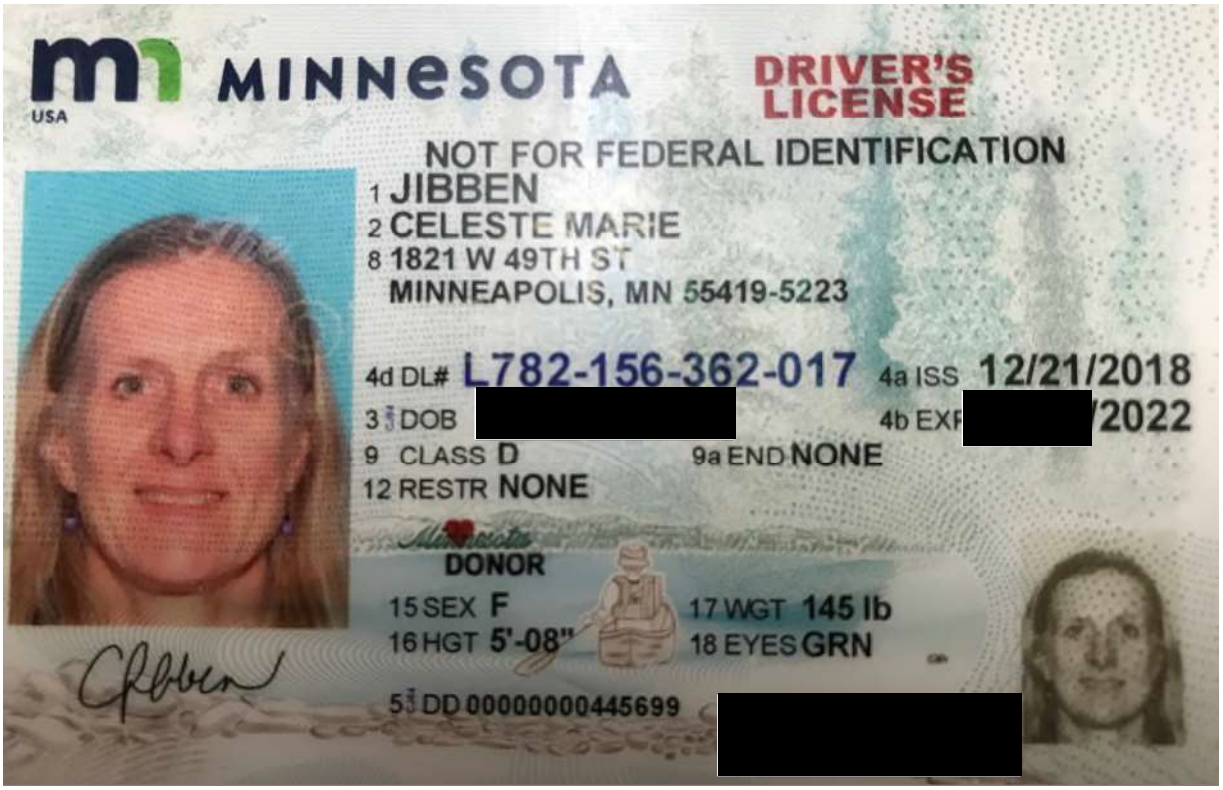
44. Submission Date:
04/22/2021

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.


MINNESOTA
USA
DRIVER'S LICENSE
NOT FOR FEDERAL IDENTIFICATION
1 JIBBEN
2 CELESTE MARIE
8 1821 W 49TH ST
MINNEAPOLIS, MN 55419-5223
4d DL# L782-156-362-017
4a ISS 12/21/2018
3 DOB
4b EXP
/2022
9 CLASS D
9a END NONE
12 RESTR NONE
DONOR
15 SEX F
17 WGT 145 lb
16 HGT 5'-08"
18 EYES GRN
5 DD 00000000445699

CREDENTIAL STATUS HISTORY SUMMARY

Name: Celeste M Jibben **Date:** 8/10/2022
License: Physician DR.0038297
License Status: Active
License Status Reason: CURRENT
First Issuance date: 11/17/1999
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
Active	CURRENT	04/22/2021	Automated
Active in Renewal	ACTIVE	03/29/2021	Automated
Active	CURRENT	03/19/2019	Automated
Active in Renewal	ACTIVE	03/12/2019	Automated
Active	CURRENT	04/12/2017	Automated
Active in Renewal	ACTIVE	03/17/2017	Automated
Active	CURRENT	03/25/2015	Automated
Approved	READY TO PRINT	03/25/2015	Automated
Active in Renewal	ACTIVE	03/17/2015	Automated
Active	CURRENT	04/16/2013	Automated
Approved	READY TO PRINT	04/16/2013	Automated
Active in Renewal	ACTIVE	03/18/2013	Automated
Active	CURRENT	06/01/2011	