STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
Thomas J. Beckett
Program Administrator

1560 Broadway, Suite 775
Denver, Colorado 80202-5140
Phone (303) 894-7690

Department of Regulatory Agencies
Steven V. Berson,
Executive Director

Division of Registrations
Bruce M. Douglas, Director

Roy Romer
Governor

April 12, 1990

Douglas Alan Karpen, D.O.
202 S. John Redditt Drive
Lufkin, TX 75901

Dear Doctor:

At a meeting of the Colorado Board of Medical Examiners held on April 12, 1990, your application for Colorado medical licensure was approved.

Your license number is 30102 effective April 12, 1990.

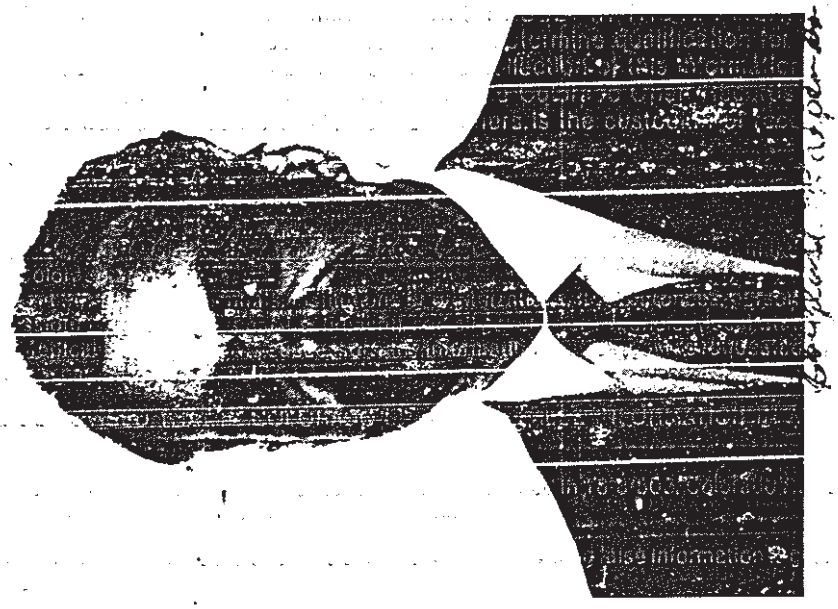
All physician licenses expire during May of each odd numbered year, and once renewed are good for a two year period. Your license will expire May 31, 1991 – please note this date. Notice of the renewal fee will be sent to you at the last address of record in our files. It is important to inform the Board of any changes in work or home address in order to ensure that your renewal packet will reach you in a timely manner. A second renewal notice is not required by law. It is the responsibility of each physician to remit the registration fee to this office, even though the original notice fails to reach the physician. The Board cannot assume responsibility for changes of address that do not reach its office.

Sincerely,

FOR THE COLORADO BOARD OF MEDICAL EXAMINERS

Thomas J. Beckett
Program Administrator

TJB/rv



I hereby declare under penalty of perjury under the laws of the State of Colorado, that the photo of myself attached hereto, was taken

on or about 7-25 19 89

my age then being [redacted] years;

color of hair BROWN;

color of eyes GRAY;

height 6 ft. 1 in.;

weight 176 lbs.;

identifying marks NONE

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, DOUGLAS A. KARPEN, D.O. 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 that 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.

Douglas A. Karpen
Signature

8-19-89
Date

LID

STATE OF COLORADO
BOARD OF MEDICAL EXAMINERS

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1525 Sherman Street, Room 132
Denver, Colorado 80203
(303) 866-2468

AUG 24 1989
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

1a. Name: Last: Karpen First: Douglas Middle: Alan Degree: D.O.

1b. Social Security Number: [redacted]

2. Other names - indicate if none: NONE

3. Mailing Address: Number and Street/Rural Route, Apartment Number: 202 S. John Redditt Drive
City: Lufkin State: Texas Zip: 75901 Country: U.S.A.

4. Telephone Number: (Area Code) Day Evening: 409-634-8343

5. Date of Birth: [redacted] Mo/Day/Year Place of Birth: Sioux City, Iowa
Submit a certified or notarized copy of your birth certificate.

6. Sex: ☑ Male ☐ Female

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

8. List name and address of all colleges or universities where pre-medical instruction was received. Pre-medical instruction is limited to that course work required for entrance to medical school.
Request an official copy of transcript, with seal of school affixed, to be sent directly from the school to this office.
If transcripts are not in English, send a certified English translation.

Name of school	Address and zip	Period of attendance From (Mo/Yr)	To (Mo/Yr)
University of South Dakota	Vermillion, South Dakota	9/66	6/70

9. List name and address of all schools where professional medical instruction was received.
Request an original Certificate of Medical Education and official copy of transcripts, with seal of school affixed, from each school attended. Certificate and transcripts must be sent directly from the school to this office. (See Form L2)
If transcripts are not in English, send a certified English translation.

Name of school	Address and zip	Period of attendance From (Mo/Yr)	To (Mo/Yr)
Kirksville College of Osteopathic Medicine	800 West Jefferson Kirksville, MO 63501	9-70	6-74

10. Doctor of Medicine/Osteopathy Degree granted by: (Submit legible photocopy)
If degree is not in English, send a certified English translation.

Name of medical school	Address and zip	Date degree conferred
Kirksville C. of O.M.	800 West Jefferson Kirksville, MO 63501	6-3-74

License # _____ Date _____

Fee $ 32.00 Date _____

PERSONAL DATA
D.O.
exhibit 8/30/89
Fee paid 8/30/89
PRE-MED EDUC
MEDICAL EDUC
CME ☑
DPL ☑
INSUR ☑

Org. 8/86
Revised 1/89

L1A

11. Have you taken any of the following written examinations: National Boards, ECFMG, FLEX, or state written exam?
☑ Yes ☐ No

If yes, request certification of scores from each examination agency, including failures, to be sent directly from examination agency to this office (See information sheet) Provide information below

Exam	Location	Date	Result
State Written	Michigan	1974	[redacted]
State Written	West Virginia	1974	

12. 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 Certificate of Completion of ACGME/AOA-approved internship or residency training from each facility (See Form L3)

Name of facility	Address and zip	Specialty	Period of attendance From (Mo/Yr)	To (Mo/Yr)
Doctors and Grady hospital	Tucker, GA 30084	Rotating Intern.	6-74	7-75

13a. Are you now or have you ever been licensed to practice medicine in any state, territory, district, or country? (See form L4) ☑ Yes ☐ No

If yes, provide information below

State or country	License number	Date of issue	Dates of practice in this jurisdiction From (Mo/Yr)	To (Mo/Yr)
Texas	E5127	1975	7-75	Present
West Virginia	601	1974	Never	
Georgia	17461	1974	Internship only	
Michigan	E6756	1974	Never	
TENNESSEE	D0789	1989	Never	

13b. 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? (See Form L6) ☑ Yes ☐ No

14. 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? NO If yes explain on a separate sheet and provide verification of same from insurance company or state licensing board.

15. Have you ever been notified by any state, territory, district, country, U.S. government agency, state medical/osteopathic board of any complaint against you relative to the practice of medicine? This includes, but is not limited to, any allegations currently pending. ☐ Yes ☑ No

If yes, give details below:

State	Date	Charge	Disposition

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

If yes, give details below

State or government agency	Date	Charge	Disposition

OFFICE USE ONLY

WRITTEN EXAM

POSTGRAD TRAINING

LICENSE DATA

REQ REC

L1B

OFFICE USE ONLY

LICENSE DATA (continued)

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

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 payment of the renewal fee.

☐ Yes ☑ No

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

State	Date	Reason for surrender

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

20. Do you now have, or have you ever had, a physical or mental condition which might affect your ability to practice medicine?

[redacted]

If yes, explain on a separate sheet. Give dates of onset, description of condition, description of treatment, name and address of treater, current status of condition.

21. Are you now, or were you in the past, addicted to, abusive of, in treatment for abuse of any controlled substances, habit-forming drugs, prescription medication or alcohol?

[redacted]

If yes, explain on a separate sheet of paper. If treated, give name, address and zip of both facility and treater, dates of treatment, current status of condition.

22. 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 relating to the manufacture, distribution or dispensing of controlled substances, or relating to drug abuse, including alcohol?

☐ Yes ☑ No

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

Date	Court address and zip	Violation	Penalty or disposition

23. 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

GENERAL DATA

LIC

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1525 Sherman Street, Room 132
Denver, Colorado 80203
(303) 866-2468

BOARD OF MEDICAL EXAMINERS
SEP 01 1989
STATE OF COLORADO

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW.

This certifies that DOUGLAS ALAN KARPEN (FULL NAME OF APPLICANT)

of JEFFERSON, SOUTH DAKOTA (ADDRESS WHEN ENROLLED) enrolled in KIRKSVILLE COLLEGE OF OSTEOPATHIC MEDICINE (NAME OF MEDICAL SCHOOL)

KIRKSVILLE, MISSOURI (LOCATION) on the 14 day of Sept. (MONTH) 19 70 (YEAR)

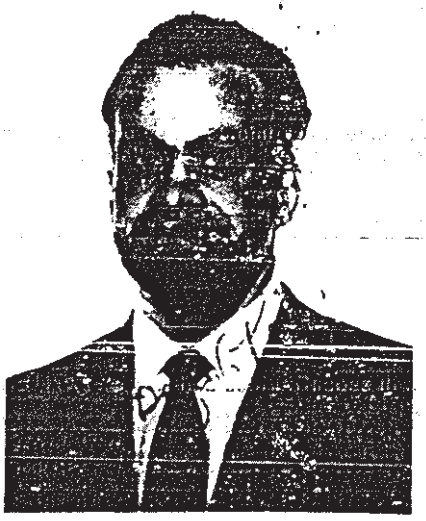
and was granted the following credits on enrollment:

Course of study	Institution	Date completed	Credit awarded

The undersigned further certifies that the records of this institution show that he attended in this institution 4 Academic years (number of years) of resident instruction, and that:

☒ s/he was granted the degree Bachelor/Doctor of Medicine or Doctor of Osteopathy, or

☐ s/he withdrew from the above mentioned medical/osteopathic school on the 3rd day of June, 19 74



Signed and the college seal affixed this 28 day of August, 19 89

BY [signature] (PRESIDENT, SECRETARY, DEAN) Registrar

NOTES TO REGISTRAR AND APPLICANT

1. Medical School Seal MUST Be Imprinted Partially on the Photograph.
2. TRANSCRIPTS OF MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE.
3. Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to the form must be original.

NOT VALID WITHOUT SCHOOL SEAL

If no school seal please indicate above next to signature of President/Secretary/Dean.

L2

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1525 Sherman Street, Room 132
Denver, Colorado 80203
(303) 866-2468

SEP 06 1989

STATE OF COLORADO

CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

TO BE COMPLETED BY THE FACILITY FOR EVERY MEDICAL/OSTEOPATHIC SCHOOL GRADUATE COMPLETING POSTGRADUATE TRAINING IN THE UNITED STATES OR CANADA. DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT IS NOT ATTACHED BELOW. PLEASE TYPE OR PRINT.

This is to certify that DOUGLAS ALAN KARPEN
NAME OF APPLICANT

a graduate of KIRKSVILLE COLLEGE OF OSTEOPATHIC MEDICINE
NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in DOCTORS HOSPITAL
NAME AND ADDRESS OF FACILITY
2160 IDLEWOOD ROAD
TUCKER, GEORGIA 30084

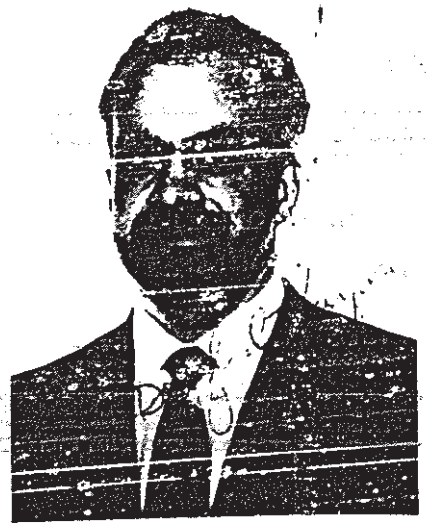
on July 1, 1974 and satisfactorily completed such training

on June 30, 1975. 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
Rotating internship	12 months

WAS THIS PHYSICIAN'S PERFORMANCE COMPLETELY SATISFACTORY?
[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 and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

NAME [signature]
PROGRAM DIRECTOR

(AFFIX INSTITUTIONAL SEAL) **NOT VALID WITHOUT SEAL**

ADDRESS 1455 Montreal Road
Tucker, GA 30084

PHONE NUMBER (404) 270-3143

DATE 8/30/89

SIGNATURE Velda L. Lesley

Notary Public, DeKalb County, Georgia
My Commission Expires Aug. 29, 1992

L3

Department of Regulatory Agencies
Division of Registrations

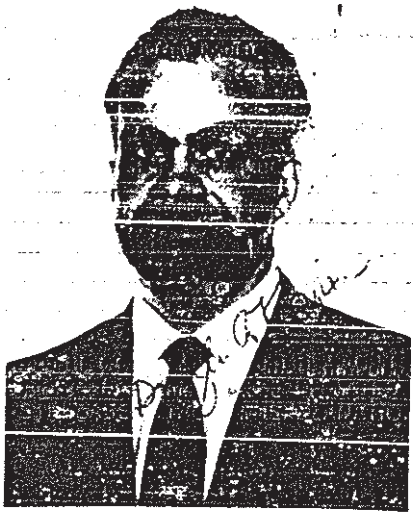
STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
1525 Sherman Street, Room 132
Denver, Colorado 80203
(303) 866-2468

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

BOARD OF MEDICAL EXAMINERS

TO BE COMPLETED BY APPLICANT:



1. NAME (last first middle): Karpen Douglas Alan

AUG 28 1989

2. ADDRESS: Number and street/rural route (include apt. no., if any): 202 S. John Redditt Dr.

STATE OF COLORADO

CITY: Lufkin STATE: Texas ZIP CODE: 75901 USA

3. DATE OF BIRTH (mo. day yr.): [redacted]

4. SEX: ☐ Female ☒ Male

5. STATE LICENSING AGENCY: TEXAS

6. LICENSE NUMBER: E5127

7. DATE OF ISSUANCE: 1975

8. DATE OF EXPIRATION: 05-31-90

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.

Douglas A. Karpen — 8-18-89

SIGNATURE — DATE

TO BE COMPLETED BY STATE LICENSING AGENCY: (Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that _____ (NAME OF APPLICANT) who graduated from _____ (NAME OF MEDICAL SCHOOL) on _____ (DATE OF GRADUATION) was granted license number _____ on _____ (DATE LICENSE ISSUED) on the basis of _____ (FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Issued on Credentials.

I further certify that this doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE) and obtained a general average of _____ per cent in the following subjects

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

Is this license valid & current? _____ Has it ever been suspended or revoked? _____ When does it expire? _____ (date)

According to your records, are there now or have there ever been any charges filed against this licensee? _____ Is there any investigation pending regarding this licensee? _____ IF THIS APPLICANT'S RECORD IS NOT COMPLETELY CLEAR IN REGARD TO THESE QUESTIONS, PLEASE ATTACH AN EXPLANATION.

NOT VALID WITHOUT SEAL

(AFFIX LICENSING AGENCY SEAL)

TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL — NAME OF STATE LICENSING AGENCY

SIGNATURE OF AGENCY OFFICIAL — ADDRESS

DATE — PHONE NUMBER

L4

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

STATE OF COLORADO

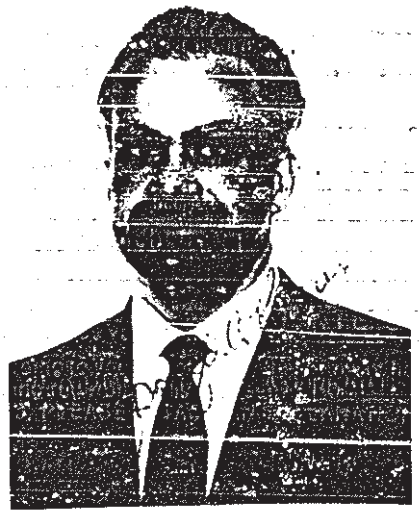
Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1525 Sherman Street, Room 132
Denver, Colorado 80203
(303) 866-2468

AUG 31 1989

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

TO BE COMPLETED BY APPLICANT: (Please type or print neatly)



1. NAME (last) (first) (middle): Karpen Douglas Alan
2. ADDRESS Number and street/rural route (include apt. no., if any): 202 S. John Redditt Dr.
CITY: Lufkin STATE: Texas ZIP CODE: 75901 COUNTRY: USA
3. DATE OF BIRTH mo/day/yr: [redacted]
4. SEX: ☐ Female ☒ Male
5. STATE LICENSING AGENCY: WEST VIRGINIA
6. LICENSE NUMBER: 601
7. DATE OF ISSUANCE: 1974
8. DATE OF EXPIRATION: 1984

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.

SIGNATURE: Douglas A. Karpen DATE: 8-18-89

TO BE COMPLETED BY STATE LICENSING AGENCY: (Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that Douglas A. Karpen, D.O. (NAME OF APPLICANT) who graduated from Kirksville College Osteopathic Medicine (NAME OF MEDICAL SCHOOL) on June 3, 1974 (DATE OF GRADUATION) was granted license number 601 on July 1, 1975 (DATE LICENSE ISSUED) on the basis of West Virginia State Licensing Exam. (FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Issued on Credentials.

I further certify that this doctor [redacted] the REGULAR WRITTEN EXAMINATION given by this Board on December 1974 (DATE) and obtained a general average of [redacted] per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent
See attached.			

Is this license valid & current? No Has it ever been suspended or revoked? No When does it expire? June 30, 1985 (date)

According to your records, are there now or have there ever been any charges filed against this licensee? No Is there any investigation pending regarding this licensee? No IF THIS APPLICANT'S RECORD IS NOT COMPLETELY CLEAR IN REGARD TO THESE QUESTIONS, PLEASE ATTACH AN EXPLANATION.

NOT VALID WITHOUT SEAL

(AFFIX LICENSING AGENCY SEAL)

TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL: Joseph E. Schreiber, D.O.

NAME OF STATE LICENSING AGENCY: West Virginia Board of Osteopathy

SIGNATURE OF AGENCY OFFICIAL: J. E. Schreiber

ADDRESS: 334 Penco Road
Weirton, WV 26062

DATE: August 25, 1989

PHONE NUMBER: 1-304-723-4638

14

STATE OF COLORADO

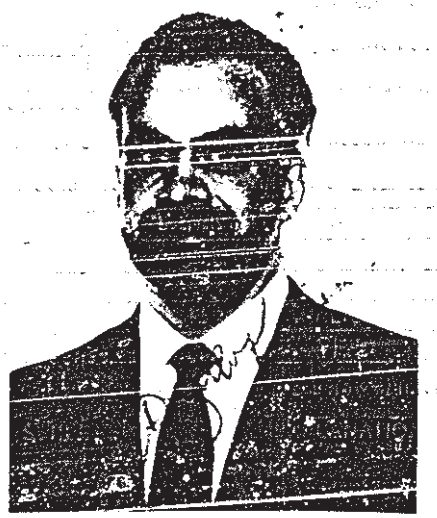
Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1525 Sherman Street, Room 132
Denver, Colorado 80203
(303) 866-2468

OCT 02 1989
STATE OF COLORADO

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

TO BE COMPLETED BY APPLICANT:



1 NAME (last) (first) (middle): Karpen Douglas Alan

2 ADDRESS Number and street/rural route (include apt. no., if any): 202 S. John Reddit Dr.

CITY: Lufkin | STATE: Texas | ZIP CODE: 75901 | COUNTRY: USA

3 DATE OF BIRTH mo/day/yr: [redacted]

4. SEX: ☐ Female ☒ Male

5. STATE LICENSING AGENCY: GEORGIA

6 LICENSE NUMBER: 017461

7. DATE OF ISSUANCE: 2/12/76

8. DATE OF EXPIRATION: 12/31/89

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.

SIGNATURE: Douglas A. Karpen | DATE: 8-19-89

TO BE COMPLETED BY STATE LICENSING AGENCY: (Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that DOUGLAS ALAN KARPEN, DO (NAME OF APPLICANT) who graduated from KIRKSVILLE OSTEOPATHIC COLLEGE (NAME OF MEDICAL SCHOOL) on 6.3.74 (DATE OF GRADUATION) was granted license number 017461 on 02/12/76 (DATE LICENSE ISSUED) on the basis of Reciprocity of West Virginia State Board examination (FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Issued on Credentials.

I further certify that this doctor [redacted] the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE)

and obtained a general average of _____ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

Is this license valid & current? YES Has it ever been suspended or revoked? NO When does it expire? 12-31-89 (date)

According to your records, are there now or have there ever been any charges filed against this licensee? NO Is there any investigation pending regarding this licensee? No IF THIS APPLICANT'S RECORD IS NOT COMPLETELY CLEAR IN REGARD TO THESE QUESTIONS PLEASE ATTACH AN EXPLANATION.

NOT VALID WITHOUT SEAL

ANDREW WATRY, EXECUTIVE DIRECTOR
TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL

(AFFIX LICENSING AGENCY SEAL)

GA. COMPOSITE STATE BOARD OF MED EXAMINERS
NAME OF STATE LICENSING AGENCY

A. Watry
SIGNATURE OF AGENCY OFFICIAL

166 PRYOR ST., SW
ADDRESS

9/27/89
DATE

ATLANTA, GA. 30303

(404) 656-3913
PHONE NUMBER

L4

STATE OF COLORADO

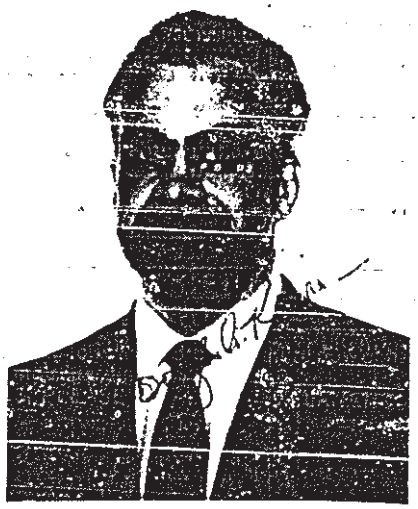
Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1525 Sherman Street, Room 132
Denver, Colorado 80203
(303) 866-2468

BOARD OF MEDICAL EXAMINERS
SEP 11 1989
STATE OF COLORADO

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

TO BE COMPLETED BY APPLICANT:
(Please type or print neatly.)



1. NAME (last) (first) (middle): Karpen Douglas Alan
2. ADDRESS: Number and street/rural route (include apt. no., if any): 202 S. John Reddit Dr.
CITY: Lufkin STATE: Texas ZIP CODE: 75901 COUNTRY: USA
3. DATE OF BIRTH: mo/day/yr [redacted]
4. SEX: ☐ Female ☒ Male
5. STATE LICENSING AGENCY: MICHIGAN
6. LICENSE NUMBER: 006756
7. DATE OF ISSUANCE: 7-1-75
8. DATE OF EXPIRATION: 3-9-77

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.

SIGNATURE: Douglas A. Karpen DATE: 8-18-89

TO BE COMPLETED BY STATE LICENSING AGENCY: (Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that _____ (NAME OF APPLICANT) who graduated from _____ (NAME OF MEDICAL SCHOOL) on _____ (DATE OF GRADUATION) was granted license number _____ on _____ (DATE LICENSE ISSUED) on the basis of _____ (FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Issued on Credentials.

I further certify that this doctor [redacted] the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE) and obtained a general average of _____ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

Is this license valid & current? _____ Has it ever been suspended or revoked? _____ When does it expire? _____ (date)

According to your records, are there now or have there ever been any charges filed against this licensee? _____ Is there any investigation pending regarding this licensee? _____ IF THIS APPLICANT'S RECORD IS NOT COMPLETELY CLEAR IN REGARD TO THESE QUESTIONS, PLEASE ATTACH AN EXPLANATION.

NOT VALID WITHOUT SEAL

(AFFIX LICENSING AGENCY SEAL)

TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL

NAME OF STATE LICENSING AGENCY

SIGNATURE OF AGENCY OFFICIAL

ADDRESS

DATE

PHONE NUMBER

T. OF LIC. & RE
OSTEO

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STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1525 Sherman Street, Room 132
Denver, Colorado 80203
(303) 866-2468

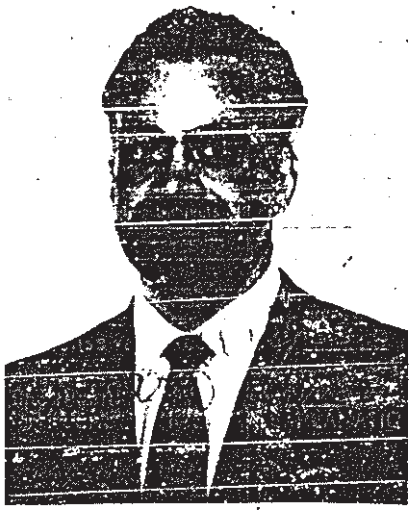
SEP 20 1989

STATE OF COLORADO

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

443123
C7/008-1C

TO BE COMPLETED BY APPLICANT:



1 NAME (last) (first) (middle): Karpen Douglas Alan			
2 ADDRESS (Number and street/rural route (include apt. no., if any)): 202 S. John Reddit Dr.			
CITY: Lufkin	STATE: Texas	ZIP CODE: 75901	COUNTRY: USA
3 DATE OF BIRTH (mo. day/yr): [redacted]	4 SEX: ☐ Female ☒ Male	5. STATE LICENSING AGENCY: TENNESSEE	
6 LICENSE NUMBER: D0789	7. DATE OF ISSUANCE: 5-26-89	8. DATE OF EXPIRATION: 5-26-90	

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.

Douglas A. Karpen — SIGNATURE
8.18.89 — DATE

TO BE COMPLETED BY STATE LICENSING AGENCY: (Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that Douglas Alan Karpen (NAME OF APPLICANT) who graduated from Kirksville College (NAME OF MEDICAL SCHOOL) on 6/3/74 (DATE OF GRADUATION) was granted license number D0789 on 5-26-89 (DATE LICENSE ISSUED) on the basis of reciprocity (FLEX NATIONAL BOARD EXAM LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Issued on Credentials.

I further certify that this docto[redacted] the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE)

and obtained a general average of _____ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

Is this license valid & current? Yes Has it ever been suspended or revoked? No When does it expire? 12-31-89 (date)

According to your records, are there now or have there ever been any charges filed against this licensee? No Is there any investigation pending regarding this licensee? No IF THIS APPLICANT'S RECORD IS NOT COMPLETELY CLEAR IN REGARD TO THESE QUESTIONS, PLEASE ATTACH AN EXPLANATION.

NOT VALID WITHOUT SEAL

Colin H. Threlkeld Secretary — TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL

(AFFIX LICENSING AGENCY SEAL) Tennessee Board of Osteopathic Examination — NAME OF STATE LICENSING AGENCY

Colin H. Threlkeld — SIGNATURE OF AGENCY OFFICIAL

283 Plus Park Blvd. — ADDRESS

Nashville, TN 37247

9-15-89 — DATE

615-367-6393 — PHONE NUMBER

LA

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
1525 Sherman Street, Room 132
Denver, Colorado 80203
(303) 866-2468

BOARD OF MEDICAL EXAMINERS

AUG 24 1989

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS

JAN 1 1990

STATE OF COLORADO

REPORT OF PRACTICE HISTORY

INSTRUCTIONS

1. List all of your experience in medical practice since medical school including all training programs (after internship) and all hospitals in which you held privileges for the last five years. Explain gaps greater than one month if you have not practiced medicine, so state.

2. Request one letter of verification for each hospital staff, clinic, private practice or any other medical practice and training programs (after internship) or any other medical position held during the last five years. Each letter should be written by the chief of staff or chief administrative officer, and must verify dates of practice, 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.

	Facility Name / Address and Zip	Reference (name & title)	Dates of Practice From—To	Nature of Practice
PRIVATE PRACTICE QUINN	2025 S. JOHN REDDITT DR. LUFKIN, TEXAS 75901	EAST TEXAS FAMILY MEDICAL CENTER NAME CHANGED TO: DOCTORS MEDICAL CENTER	1975 1986	FAMILY PRACTICE (OWNER) (INCLUDING OB + SURG.)
2.	MEMORIAL HOSPITAL LUFKIN, TX. 75901 (NOW MEMORIAL MEDICAL CENTER OF EAST TEXAS	STAFF MEMBER	1975 - THROUGH 1984	FAMILY PRACTICE, OB + SURG.
3.	WOODLAND HEIGHTS HOSPITAL LUFKIN TX. 75901 (NOW WOODLAND HEIGHTS MEDICAL CENTER)	STAFF MEMBER	1975 THROUGH 1986	FAMILY PRACTICE OB + SURGERY.
4.	DURING 1975-1980, RECEIVED MAJOR OB-GYN SURGICAL PRIVILEGES PER GRANDFATHER CLAUSE IN SURGERY AT MEMORIAL + WOODLAND HEIGHTS HOSP.S			
5.	OWNED + OPERATED OUT-PATIENT CLINICS LUFKIN, TX. + HOUSTON, TX.		1986 1989	FAMILY PRACTICE GYN.
6	VOLUNTARILY GAVE UP STAFF PRIVILEDGES BECAUSE UNABLE TO			
7.	ATTEND MEETINGS OR PARTICIPATE IN COMMITTEE WORK, etc. SINCE BEING OUT OF TOWN MUCH OF TIME.			
8.	MEMBER ANGELINA COUNTY MEDICAL SOCIETY AMA; TMA; TOMA.			
9.				
10.				

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

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

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

SIGNATURE Douglas Harpem

DATE 8-19-89

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STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
1525 Sherman Street, Room 132
Denver, Colorado 80203
(303) 866-2468

BOARD OF MEDICAL EXAMINERS

AUG 24 1989

STATE OF COLORADO

REPORT OF PRACTICE HISTORY

INSTRUCTIONS

1. List all of your experience in medical practice since medical school including all training programs (after internship), and all hospitals in which you held privileges for the last five years. Explain gaps greater than one month. If you have not practiced medicine, so state.

2. Request one letter of verification for each hospital staff, clinic, private practice, or any other medical practice and training programs (after internship) or any other medical position held during the last five years. Each letter should be written by the chief of staff or chief administrative officer, and must verify dates of practice, 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.

	Facility Name / Address and Zip	Reference (name & title)	Dates of Practice From + To	Nature of Practice
1	2025 JOHN REDDITT DR. LUFKIN, TEXAS 75901	EAST TEXAS FAMILY MEDICAL CENTER NAME CHANGED TO: DOCTORS MEDICAL CENTER	1975 1986	FAMILY PRACTICE (INCLUDING OB + SURG.)
2.	MEMORIAL HOSPITAL LUFKIN, TX. 75901	STAFF MEMBER	1975 1987	FAMILY PRACTICE, OB + SURG.
3.	WOODLAND HEIGHTS HOSPITAL LUFKIN TX. 75901	STAFF MEMBER	1975 1987	FAMILY PRACTICE OB + SURGERY.
4.	DURING 1975-1980, RECEIVED MAJOR OB-GYN SURGICAL PRIVILEGES PER GRANDFATHER CLAUSE IN SURGERY AT MEMORIAL + WOODLAND HEIGHTS HOSPS			
5	DUNED + OPERATED OUT-PATIENT CLINICS LUFKIN, TX. & HOUSTON, TX.		1986 1989	FAMILY PRACTICE GYN.
6.	VOLUNTARILY GAVE UP STAFF PRIVILEDGES BECAUSE UNABLE TO			
7.	ATTEND MEETINGS OR PARTICIPATE IN COMMITTEE WORK, etc. SINCE BEING OUT OF TOWN MUCH OF TIME.			
8.	MEMBER ANGELINA COUNTY MEDICAL SOCIETY AMA; TMA; TOMA.			
9.				
10.				

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

SIGNATURE Douglas A. Karpen DATE 8-19-89

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BOARD OF MEDICAL EXAMINERS

SEP 11 1989

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS
Thomas J. Beckett
Program Administrator
1525 Sherman St., Room 132
Denver, Colorado 80203
Phone (303) 866-2468

STATE OF COLORADO

Department of Regulatory Agencies
Steven V. Benson,
Executive Director

Division of Registrations
Bruce M. Douglas, Director

Roy Romer
Governor

DISCIPLINARY INQUIRIES

Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

The Colorado State Board of Medical Examiners requests a disciplinary search concerning the following individual:

Douglas Alan Karpen, D.O.
NAME

202 S. John Redditt Drive
ADDRESS

Lufkin, TX 75901
CITY, STATE AND ZIP

[redacted]
DATE OF BIRTH

[redacted]
SOCIAL SECURITY NUMBER

Kirksville C. of Osteo. Med., MO
MEDICAL SCHOOL OF GRADUATION AND BRANCH LOCATION

6-3-74
DATE OF GRADUATION

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

SEP - 6 1989

Bryant L. Galusha, M.D.
BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE-PRESIDENT

Please mail the response to the following address:

1525 Sherman Street, Room 132
Denver, Colorado 80203 (303) 866-2468

ATTENTION:

Rosemary Wisekarte
Signature

STATE OF MICHIGAN

BOARD OF MEDICAL EXAMINERS

SEP 11 1989

STATE OF COLORADO

JAMES J. BLANCHARD, Governor

DEPARTMENT OF LICENSING AND REGULATION

RAYMOND W. HOOD, SR., Director
P.O. Box 30018
Lansing, Michigan 48909
Telephone (517) 373-1870
Telecommunication Device for the Deaf (517) 335-4478

September 6, 1989

State of Colorado
Board of Medical Examiners
1525 Sherman St., Room 132
Denver, CO 80203

TO WHOM IT MAY CONCERN:

I hereby certify that a standard search of the available records of the Michigan Department of Licensing and Regulation, Bureau of Health Services, indicates the following:

DOUGLAS A. KARPEN, D.O.

WAS ISSUED LICENSE NO.:	006756
ON:	July 1, 1975
TO PRACTICE AS A:	Osteopathic Physician & Surgeon
LICENSURE STATUS IS:	Lapsed on March 7, 1977 due to non renewal.
ISSUED ON THE BASIS OF:	Michigan Board Examination
REGULATORY INFORMATION:	None

The above format is the standard format prepared for all the professions regulated by this Bureau. If other information is needed, please contact this office at (517) 373-6650.

Sincerely,

(SEAL)

Lisa Olney
Administrative Support Staff

Texas State Board of Medical Examiners

1101 CAMINO LA COSTA, SUITE 201
P.O. BOX 13562, CAPITOL STATION
AUSTIN, TEXAS 78711

(512) 452-1078

BOARD OF MEDICAL EXAMINER

AUG 28 1989

STATE OF COLORADO

COLORADO BOARD OF
MEDICAL EXAMINERS
132 STATE SERVICES BUILDING
1525 SHERMAN ST.
DENVER, CO 80203

****

Physician: DOUGLAS ALAN KARPEN, DO
License: F5127
Date Issued: 12-02-75
Licensed By: Reciprocity with MICHIGAN
Date of Birth: [redacted]
Medical School: KIRKSVILLE COLL OF OSTEO AND SURG, KIRKSVILLE
Graduation Year: 1974
Permit Expires: 05-31-90

This is to certify that the above-named physician is licensed to practice medicine in Texas and that the board has not filed any formal complaints or statements of charges against this physician.

****

Janice Harris Date: AUGUST 24, 1989
Registration Division

BOARD SEAL

To expedite the board's verification process, the above format is the standard format prepared for physicians licensed by this agency. If you have any further questions, please contact the Registration Division.