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) 894-7880
FAX: (303) 894-7692
www.dora.state.co.us/medical/

APD 5865

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	First	Middle	Degree	1b. Social Security Number
HASKELL	SUE	C	D.O.	[redacted]

PERSONAL DATA

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

SUSAN CAROL ABENDSCHEIN HASKELL

L7 ☒

3 Mailing Address Number and Street/Rural Route, Apartment Number — This is my home ☒ business ☐ NOTE Address provided is, by law, public information

4013 LINCOLN PL DR DES MOINES IA 50312 USA

City State Zip Country

NPDB ☐

e-mail address [redacted]

4. Telephone Number (Area Code) Day (Evening)

515-255-6543

5 Date of Birth: Mo/Day/Year [redacted] Place of Birth NIAGARA FALLS, NY

Submit a certified or notarized copy of your birth certificate or passport.

BC ☒

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 college or university where pre-medical degree was received.

PRE-MED EDUC

Name of School	Address and zip	Period of attendance From (Mo/Yr)	Period of attendance To (Mo/Yr)
DREW UNIV.	MADISON, NJ 07940	9-60	6-64
DRAKE UNIV	DES MOINES, IA 50311	9-74	5-77

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.

MEDICAL EDUC
L2 ☒

Name of School	Address and zip	Period of attendance From (Mo/Yr)	Period of attendance To (Mo/Yr)
COMS	DES MOINES IA 50312	6-77	6-80
now Des Moines University			

Org 8/86
Revised 9/92
Revised 11/95
Revised 4/96
Revised 12/96
Revised 1/97
Revised 11/98
Revised 8/99

Official use only

License [redacted] Date 2/9/00

Fee [redacted] Date 11/22/99

L1A

OFFICE USE ONLY

[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.

Name of facility	Address and zip	Specialty	Period of attendance	
			From (Mo/Yr)	To (Mo/Yr)
DES MOINES GEN. HOSP.	DSM, IA 50309	ROTATING INTERNSHIP	7-80	8-81

[redacted]

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.**

State or country	License number	Date of issue	Dates of practice in this jurisdiction	
			From (Mo/Yr)	To (Mo/Yr)
IOWA	1898	EXP 3-1-2001	8-81	present
NEBRASKA	173	EXP. 10-1-2000	10-95	present

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:

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.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question ☐ Yes ☒ No

If yes, give details below:

State or government agency	Date	Charge	Disposition

POSTGRAD TRAINING

☑

☐

☐

LICENSE DATA

☑

☑

☐

☐

☐

L6 ☑

REQ REC

☐ ☐

☐ ☐

☐ ☐

REQ REC

☐ ☐

☐ ☐

L1B

OFFICE USE ONLY

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

LICENSE DATA (continued)

REQ REC

☐ ☐

☐ ☐

17 Have you ever been denied or withdrawn an application for 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 or withdrawal

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

☐ ☐

L1C

Office use only

LICENSE DATA (continued)

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	REQ	REC
			☐	☐
			☐	☐
			☐	☐
			☐	☐

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

REQ ☐ REC ☐

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. B – 6 below

INS ☒

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, Ina Harrell DO, 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

Ina Harrell DO
Signature

11-17-99
Date

B.6. I currently reside outside of Colorado and claim exemption number 6 - the agency for which I might work carries appropriate professional liability coverage (Planned Parenthood of Rocky Mountains)

Ina Harrell DO

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	Des Moines General Hospital	603 E. 12th St Des Moines IA 50309	Director of medical Education	7/80 - 8/81	Rotating Internship
2.	—	Norm - had brain surgery during internship		8-81 to 2/82	—
3.	Perry Medical clinic	Perry IA 50220 Dr Saul Siegel - deceased	gone	2/82 - 6/82	helping DO with heart trouble
4	Iowa Correctional Institution for Women - Mitchellville IA 50169		?	6/82 - 2/83	physician for women prisoners
5.	Altoona	Family Practice Center PC Altoona IA 50009	gone	8/82 - 1/91	physician, partner, owner
6.	Planned 851 - 6th St.	Parenthood of Greater Iowa Des Moines IA 50314	Penny Divay RN VP for medical Services	11/89 - present	medical director physician
7					
8.			BOARD OF MEDICAL EXAMINERS NOV 22 1999 STATE OF COLORADO		
9					
10					

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

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L6

Ann Haskell DO — SIGNATURE
HASKELL — PRINT LAST NAME
11-17-99 — DATE

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT GOVERNOR

BOARD OF MEDICAL EXAMINERS
ANN E MOWERY, PHD, EXECUTIVE DIRECTOR

December 16, 1999

Colorado State Board of Medical Examiners
1560 Broadway, Ste 1300
Denver, CO 80202-5140

This serves as official verification that the physician listed below has a license to practice in the state of Iowa.

PHYSICIAN:	Haskell, Susan Carol A
[redacted]	
LICENSE NUMBER:	01898
LICENSE TYPE:	Permanent - DO
HOW OBTAINED:	National Boards
DATE ISSUED:	October 21, 1981
EXPIRATION DATE:	March 1, 2001
STATUS:	Active

[redacted]

The above format is the standard format prepared for all physicians regulated by this board. All physicians are considered in good standing unless otherwise noted [redacted]

Sincerely,

Sylvia H. Crook

Sylvia H. Crook
Licensing Section
Iowa Board of Medical Examiners
(515) 281-5172

VERCONFRTF

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANNS, GOVERNOR

Please reply to: Credentialing Division, PO Box 94986, Lincoln NE 68509-4986
Phone #: (402) 471-2118 Fax #: (402) 471-3577

BOARD OF MEDICAL EXAMINERS
NOV 29 1999
STATE OF COLORADO

CERTIFICATION OF LICENSE

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

PROFESSION NAME: Osteopathic Physician & Surgeon

Number. 173 Status Active
Issuance Date 07/11/1995 Expiration Date 10/01/2000

Name Susan Carol Haskell DO
Address 4013 Lincoln Pl Dr
Des Moines, IA 50312

Credential Obtained by Reciprocity
School/Graduation Date COL OSTEO MED IA 06/06/1980
Date of Birth [redacted]
Place of Birth NEW YORK

[redacted]

To expedite the certification process, the Credentialing Division is using the above format. [redacted]

Helen L Meeks, Division Administrator
Credentialing Division

November 24, 1999

You may verify licenses under the following Internet Web Site Address: http://www.hhs.state.ne.us/lis/lis.asp

(SEAL)

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

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 SUSAN CAROL ABENDSCHEIN HASKELL
FULL NAME OF APPLICANT

a graduate of COLLEGE OF OSTEOPATHIC MEDICINE + SURGERY
FULL NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in DES MOINES GENERAL HOSPITAL
NAME AND ADDRESS OF FACILITY
603 - E. 12th ST. DES MOINES IA 50309

[redacted]

on August 19 81. 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 ROTATING INTERNSHIP LENGTH OF ROTATION 12

[redacted]

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 Glenda D Shannon

ADDRESS 603 E. 12th St
Des Moines IA 50309

PHONE NUMBER 515-263-4794

DATE 11-23-99

SIGNATURE Glenda D Shannon

L3

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

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Denver, Colorado 80202-5140
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FAX: (303) 894-7692

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that SUSAN CAROL ABENDSCHEIN HASKELL
FULL NAME OF APPLICANT

of 4013 LINCOLN PL DR DES MOINES IOWA 50312
ADDRESS WHEN ENROLLED

enrolled in COLLEGE OF OSTEOPATHIC MEDICINE + SURGERY
FULL NAME OF MEDICAL SCHOOL

DES MOINES IOWA on the 30 day of JUNE ,19 77
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 27 day of June ,1977 and was granted the degree Bachelor/Doctor of Medicine or (Doctor Osteopathy) on the 6 day of June ,19 80

Signed and the college seal affixed

this 18 day of November ,19 99.

By Kathryn Dufore ,Registrar

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:

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

L2

COLORADO BOARD OF MEDICAL EXAMINERS
2001 LICENSE RENEWAL QUESTIONNAIRE

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #	LICENSE #
HASKELL	SUE	C	[redacted]	38454

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.

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 payment 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 [redacted]

HAVE YOU PREVIOUSLY REPORTED ANY OF THE ABOVE MATTERS TO THE BOARD?
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 _____

- ☐ 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

☐ INACT E 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

Sue Haskell DO 5-4-01

Signature of Physician **Date**

SUE C. HASKELL D.O. 38454

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