

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS

Thomas J. Beckett
Program Administrator

1560 Broadway, Suite 1300
Denver, Colorado 80202-5100
Phone: (303) 894-6900

Department of Regulatory Agencies

Steven V. Benson,
Executive Director

Division of Registrations
Bruce M. Douglas, Director



Roy Romer
Governor

July 24, 1992

Sincerely,
Stephen Mark Volin, M.D.
7814 Holmes Run Drive
Falls Church, VA 22042

Dear Dr. Volin:

At a meeting of the Colorado Board of Medical Examiners held on July 16, 1992, your application for Colorado medical licensure was approved.

Your license number is 32006 effective July 16, 1992.

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, 1993 - 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 BOARD OF MEDICAL EXAMINERS


Thomas J. Beckett
PROGRAM ADMINISTRATOR

TJB/lj

STATE OF COLORADO

Department of Regulatory Agencies
Division of Registrations

BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5110
Phone (303) 894-4400



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

VOLIN Stephen Mark MD [REDACTED]

2. Other names - indicate if none.

none

3. Mailing Address: Number and Street/Rural Route, Apartment Number

7814 Holmes Run Drive

Falls Church, VA 22042 US

4. Telephone Number: (Area Code) Day Evening 5. Date of Birth: Mo/Day/Year Place of Birth:

703 573 5304 [REDACTED] San Jose Calif.

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)
Dartmouth College	6003 Parkhurst Hanover NH 03755	8/80	6/84

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)
University of Texas Southwestern Medical School	5323 Harry Hines Blvd Dallas TX 75235-9096	8/84	6/88

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
University of Texas Southwestern Medical School	5323 Harry Hines Blvd Dallas TX 75235-9096	6/88

PERSONAL DATA

PRE-MED SCHOOL

MEDICAL EDUCATION

DATE

DATE

Org. 8/86
Revised 11/90

JR

LIC. 32006
32900
5/28/92

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
FLEX	Austin TX	6/88	[REDACTED]

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)
George Washington University Hospital	901 23rd St NW Washington DC 20037	Ob/gyn	6/88	6/92

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)
Washington DC	18452	8/90	1/91	12/92

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:

Indicate if complaint(s) is a malpractice suit (s)

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

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

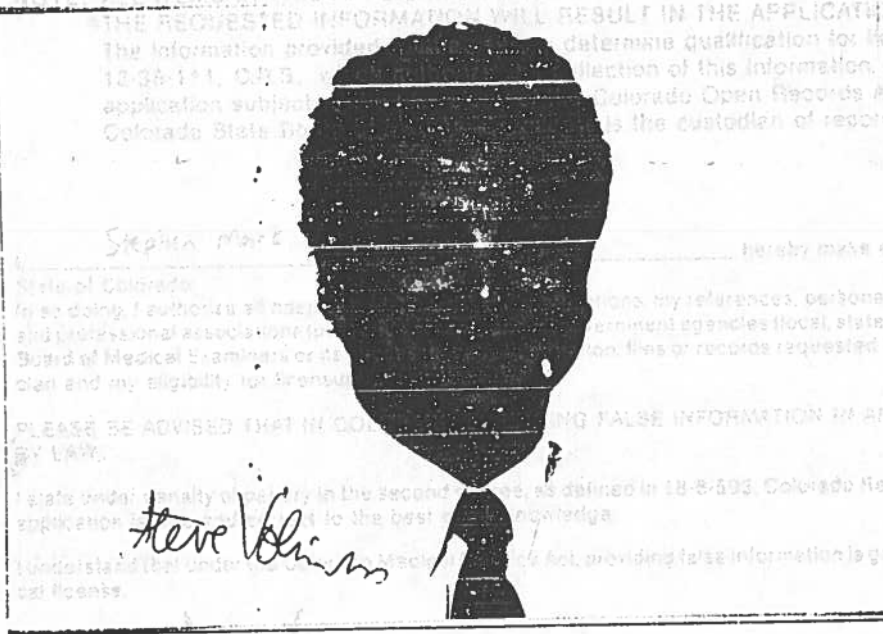
If yes, give details below: Include any conviction that has been set aside, dismissed, or pardoned under the Constitution of Colorado, article IV, section 7, or under any other provision of law.

Date	Court address and zip	Violation	Penalty or disposition

24. You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado law, or state basis for exemption. See instructions in application packet.



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.



Stephen Mark Volin
Steve Volin MS

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 5/10 1992

my age then being years;
color of hair Brown;
color of eyes green;
height 5 ft. 8 in. ;
weight 170 lbs. ;
identifying marks

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.

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, Stephen Mark Volin 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.

Steve Volin MS
Signature

5/10/92
Date

Department of Regulatory Agencies
Division of Registrations

STATE OF COLORADO
BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1500
Denver, Colorado 80202-5140
Phone (303) 894-7690

MAY 28 92



CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Steve Mark Volin FULL NAME OF APPLICANT
of 10111 Jaydee Blvd. Fairfax Station, VA enrolled in UT Southwestern Medical School NAME OF MEDICAL SCHOOL
5323 Harry Hines Blvd Dallas, TX 75235 on the 20 day of August 19 84
LOCATION MONTH YEAR

and was granted the following credits on enrollment:

Course of study	Institution	Date completed	Credit awarded
MD	UT Southwestern Medical School	6/3/88	-
	5323 Harry Hines Blvd.		
	Dallas, TX 75235-9096	MD Degree	June 4, 1988

The undersigned further certifies that the records of this institution show that he attended in this institution 4 YRS. of
resident instruction, and that: number of weeks

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

school on the 4 day of June 19 88

Signed and the college seal affixed this 22 day of May 19 92

BY: Val Rodriguez
PRESIDENT, SECRETARY, DEAN

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.



Steve Mark Volin MD

L2

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

COLORADO MEDICAL BOARD



JUN 26 92

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.

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

This is to certify that Steve Mark Volin, M.D.
NAME OF APPLICANT

a graduate of Southwestern Medical School
NAME OF MEDICAL/OSTEOPATHIC SCHOOL

commenced postgraduate training in Obstetrics and Gynecology at The George Washington University
NAME AND ADDRESS OF FACILITY

Medical Center, 2150 Pennsylvania Avenue, N.W., Washington, D.C. 20037

on June 23, 1988, and satisfactorily completed such training
on June 12, 1992. This training consisted of 48 months of actual clinical instruction and is approved by the Accredited Council (or 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

OBS-GYN

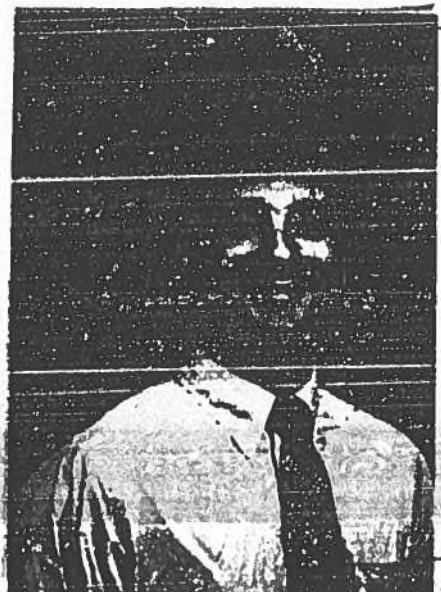
LENGTH OF ROTATION

48 months total

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

IF NO, PLEASE ATTACH AN EXPLANATION

Subscribed and sworn to before me this
17th day of June, 1992
Monica M. Parks
Notary Public
My Commission Expires
April 14, 1996



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

John Whanado
PROGRAM DIRECTOR

(AFFIX INSTITUTIONAL SEAL)

NOT VALID WITHOUT SEAL

ADDRESS The George Washington University Medical Center
Department of Obstetrics and Gynecology
2150 Pennsylvania Avenue, NW, Washington, DC 20037

PHONE NUMBER 202 994 2691

DATE June 3, 1992

SIGNATURE

John Whanado

L3

Department of Regulatory Agencies
Division of Registrations

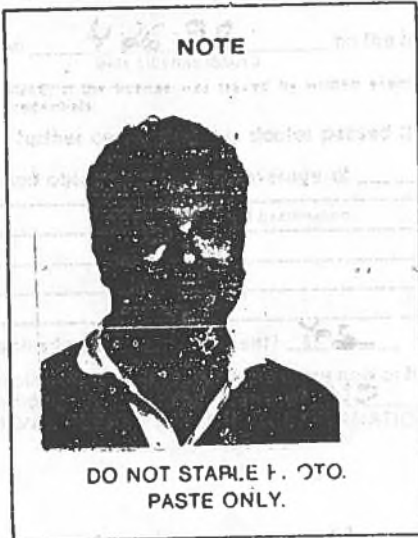
COLORADO MEDICAL BOARD
MAY 27 92

STATE OF COLORADO
BOARD OF MEDICAL EXAMINERS
1560 Broadway, Suite 1300
Denver, Colorado 80202-5140
Phone (303) 894-7690



CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

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



1. NAME (last first middle) Volin Steve Mark 18152

2. ADDRESS: Number and street/rural route (include apt. no., if any)
7814 Holmes Run Dr
CITY STATE ZIP CODE COUNTRY
Falls Church VA 22042 US

3. DATE OF BIRTH: [REDACTED] 4. SEX: Female Male 5. STATE LICENSING AGENCY
Wash. D.C.

6. LICENSE NUMBER 18452 7. DATE OF ISSUANCE: 4/90 8. DATE OF EXPIRATION

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.

Steve Volin MD 4/20/92
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 Steve Mark Volin who graduated from
NAME OF APPLICANT
U. of Texas on 1987 was granted license number 18152
NAME OF MEDICAL SCHOOL DATE OF GRADUATION
on 4.26.90 on the basis of FLEX FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM
DATE LICENSE ISSUED

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? YES Has it ever been suspended or revoked? NO When does it expire? 12-31-92 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

Jonathan W. Hawkins
TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL

(AFFIX LICENSING AGENCY SEAL)

NAME OF STATE LICENSING AGENCY

J.W. Hawkins
SIGNATURE OF AGENCY OFFICIAL

ADDRESS
Washington, D.C. 20001

DATE
5/21/92

PHONE NUMBER
(202) 727-5365

LA

STATE OF COLORADO

BOARD OF MEDICAL EXAMINERS

1560 Broadway, Suite 1300
 Denver, Colorado 80202-5140
 Phone (303) 894-7690



INSTRUCTIONS

1. List all of your experience in medical practice since medical school including all training programs (after internships) 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 internships) 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.

REPORT OF PRACTICE HISTORY

REPORT OF PRACTICE HISTORY

Facility Name	Address and Zip	Reference (name & title)	Dates of Practice From-To	Nature of Practice
George Washington Hospital Department of Ob/Gyn Washington DC 20037	401 23rd St NW	Dr John Larsen MD Professor and Acting Chairman Dept of Ob/Gyn	6/88 - 6/92	residency

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 18-6-503, 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: Steve Volin MD

DATE: 4/20/92

COLORADO MEDICAL BOARD
 JUN 26 92

Renewal - DR.0032006

Name	Stephen Mark Volin
Credential	DR.0032006

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.



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.

**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 18-3-503, 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 renew my license in ACTIVE status, therefore 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 and 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.

A. I maintain commercial professional liability insurance with COPIC, in minimum indemnity amounts of at least \$1,000,000 per incident and \$3,000,000 annual aggregate per year.

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 your 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.0032006

Name	Stephen Mark Volin
Credential	DR.0032006

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.0032006

Name	Stephen Mark Volin
Credential	DR.0032006

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
9195 Grant St Ste 410	Thornton	Colorado	80229	

HPPP - MEDICAL Education and Training

Education and Training

51. School or Education Level:

Uni of TX SW Med Ctr - Dallas Southwestern Med Sch

52. Please enter the year your initial Degree was achieved: *Only enter the year in YYYY format*
1988

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?
No

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
Obstetrics and Gynecology

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
Obstetrics and Gynecology

HPPP GLOBAL - CO Hospital Affiliations

Colorado Hospital Affiliations

59. Do you have a current affiliation or clinical privileges with any Colorado Hospital?
Yes

HPPP GLOBAL - CO Hospital Affiliations if Yes

Colorado Hospital Affiliations

60. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
North Suburban Medical Center	Admitting Privileges	Thornton
Exempla Good Samaritan Medical Center	Admitting Privileges	Lafayette

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?

Yes

HPPP GLOBAL - Other Hospital Affiliations If Yes

Other Health Care Facilities and Out of State Hospital Affiliations

62. Other Healthcare Facility Affiliations:

Facility	Affiliation Type	City	State
North Suburban ASC	Admitting Privileges	Thornton	Colorado
The Womens Health Surgery Center	Admitting Privileges	Thornton	Colorado

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
North Suburban ASC	Thornton	Colorado
The Women Health Surgery Center	Thornton	Colorado

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?

Yes

HPPP GLOBAL - Employment Contracts if Yes

Employment Contracts

68. Employment Contracts:

Entity Name	Length of Contract	Contract Position
Bard	1	Independent Contractor
The Women's Health Group	15	Employee

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?
Yes

HPPP GLOBAL - Malpractice Claims if Yes

Malpractice Claims

83. Malpractice Claims:

Year	State	Claim Type	Arbitrator, Mediator or Court
1998	Colorado	Settlement	
2001	Colorado	Settlement	
2005	Colorado	Settlement	
2006	Colorado	Settlement	Adams County District Court

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:
04/15/2017

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.0032006

Name	Stephen Mark Volin
Credential	DR.0032006

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:

04/11/2019

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 (WF)

Healthcare Professions Profile | Location of Practice

98. Practice Locations:

Address	City	State	Zip Code	Phone Number
9195 Grant St Ste 410	Thornton	Colorado	80229	

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

99. School or Education Level:

Uni of TX SW Med Ctr - Dallas Southwestern Med Sch

100. Please enter the year your initial Degree was achieved: *Only enter the year in YYYY format*

1988

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?

No

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
Obstetrics and Gynecology

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
Obstetrics and Gynecology

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?

Yes

Healthcare Profile - Colorado Hospital Affiliations if Yes

Healthcare Professions Profile | Colorado Hospital Affiliations

108. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
North Suburban Medical Center	Admitting Privileges	Thornton
Exempla Good Samaritan Medical Center	Admitting Privileges	Lafayette

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?

Yes

Healthcare Profile - Other Facility and Out of State Hospital Affiliations if Yes

Healthcare Professions Profile | Other State Hospital Affiliations

110. Other Healthcare Facility Affiliations:

Facility	Affiliation Type	City	State
North Suburban ASC	Admitting Privileges	Thornton	Colorado
The Womens Health Surgery Center	Admitting Privileges	Thornton	Colorado

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
North Suburban ASC	Thornton	Colorado
The Women Health Surgery Center	Thornton	Colorado

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?

Yes

Healthcare Profile - Employment Contracts if Yes**Healthcare Professions Profile | Employment Contracts**

116. Employment Contracts:

Entity Name	Length of Contract	Contract Position
Bard	1	Independent Contractor
The Women's Health Group	15	Employee

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**

21. 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?
Yes

Healthcare Profile - Malpractice Claims if Yes

Healthcare Professions Profile | Malpractice Claims

131. Malpractice Claims:

Year	State	Claim Type	Arbitrator, Mediator or Court
1998	Colorado	Settlement	
2001	Colorado	Settlement	
2005	Colorado	Settlement	
2006	Colorado	Settlement	Adams County District Court

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:
04/11/2019

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.0032006

Name	Stephen Mark Volin
Credential	DR.0032006

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.

Colorado 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.

*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:

04/05/2021

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
9195 Grant St Ste 410	Thornton	Colorado	80229	

Healthcare Profile - Medical Education and Training

Healthcare Professions Profile | Education and Training

8. School or Education Level:

Uni of TX SW Med Ctr - Dallas Southwestern Med Sch

9. Please enter the year your initial Degree was achieved: *Only enter the year in YYYY format*

1988

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?
 No

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
Obstetrics and Gynecology

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
Obstetrics and Gynecology

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?
 Yes

Healthcare Profile - Colorado Hospital Affiliations if Yes

Healthcare Professions Profile | Colorado Hospital Affiliations

17. Colorado Hospital Affiliations:

Hospital	Affiliation Type	City
North Suburban Medical Center	Admitting Privileges	Thornton
Exempla Good Samaritan Medical Center	Admitting Privileges	Lafayette
Rose Medical Center	Admitting Privileges	Denver

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?

Yes

Healthcare Profile - Other Facility and Out of State Hospital Affiliations if Yes

Healthcare Professions Profile | Other State Hospital Affiliations

19. Other Healthcare Facility Affiliations:

Facility	Affiliation Type	City	State
North Suburban ASC	Admitting Privileges	Thornton	Colorado
The Womens Health Surgery Center	Admitting Privileges	Thornton	Colorado

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
North Suburban ASC	Thornton	Colorado
The Women Health Surgery Center	Thornton	Colorado

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?

Yes

Healthcare Profile - Employment Contracts if Yes

Healthcare Professions Profile | Employment Contracts

25. Employment Contracts:

Entity Name	Length of Contract	Contract Position
The Women's Health Group	15	Employee
nsmc	1 year	Independent Contractor

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?
Yes

Healthcare Profile - Malpractice Claims if Yes**Healthcare Professions Profile | Malpractice Claims**

40. Malpractice Claims:

Year	State	Claim Type	Arbitrator, Mediator or Court
1998	Colorado	Settlement	
2001	Colorado	Settlement	
2005	Colorado	Settlement	
2006	Colorado	Settlement	Adams County District Court

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:

04/05/2021

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.

CREDENTIAL STATUS HISTORY SUMMARY**Name:** Stephen Mark Volin**Date:** 1/17/2023**License:** Physician DR.0032006**License Status:** Active**License Status Reason:** CURRENT**First Issuance date:** 07/16/1992**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	04/05/2021	Automated
Active in Renewal	ACTIVE	03/29/2021	Automated
Active	CURRENT	04/11/2019	Automated
Active in Renewal	ACTIVE	03/12/2019	Automated
Active	CURRENT	04/15/2017	Automated
Active in Renewal	ACTIVE	03/17/2017	Automated
Active	CURRENT	04/15/2015	Automated
Approved	READY TO PRINT	04/15/2015	Automated
Active in Renewal	ACTIVE	03/17/2015	Automated
Active	CURRENT	04/23/2013	Automated
Approved	READY TO PRINT	04/23/2013	Automated
Active in Renewal	ACTIVE	03/18/2013	Automated
Active	CURRENT	06/01/2011	

