

APPLICATION FOR PRO BONO LICENSE—PHYSICIAN

APPLICANT INSTRUCTIONS

Mandatory Practice Act. Colorado has a mandatory practice act, which means that you may not practice as a Pro Bono Physician in this state without an active Colorado license. Submission of this application does not guarantee licensure. Therefore, do not make life or career decisions based on the probability that you may receive a license. Plan ahead for the time it will take for us to receive all required documents and complete our evaluation.

Basic Requirements. Requirements for licensure are outlined in the Medical Practice Act and the Board's rules and policies. The Medical Practice Act and complete rules and policies are available online at www.dora.state.co.us/medical. In compliance with the Michael Skolnik Medical Transparency Act of 2010, licensees are required to complete an online Healthcare Professions Profile on our website at www.dora.state.co.us/hppp.

About the Application. This application is to be completed by you and returned to the Office of Licensing. All questions on the application are mandatory, and all supporting documents must be submitted with the application. You may copy as many forms as needed; however, each form submitted must be completed in original ink or typed. Keep a copy of the completed application for your records.

Application Expiration. Your application will be kept on file for one (1) year from date of receipt in the Division. Your file and all supporting documentation will be purged if you do not submit required documents and complete your application process in one year. You will need to resubmit a new application packet and fee after that time.

Social Security Number is Required. Effective January 1, 2009, a Social Security Number is required for all licensees. The Division will consider an application to be incomplete when the applicant fails to submit his/her Social Security Number. Exceptions are made for foreign nationals not physically present in the United States and for non-immigrants in the United States on student visas who do not have a Social Security Number. These applicants must submit a signed Social Security Number Affidavit in lieu of a Social Security Number. The affidavit is available on our website at www.dora.state.co.us/registrations/SSNAffidavit.pdf, or you may call (303) 894-7800 to request that one be mailed to you.

Disclosure of Addresses. Consistent with Colorado law, all addresses and phone numbers on record with the Division are public record and must be provided to the public when requested. It is your responsibility to keep your address and contact information up-to-date in our database. All letters, renewal notices, and licenses are mailed to the last known address of record. **If your address is not current, it is possible you will not receive important documents.** You can change your address online by using Registrations Online Services at www.doradls.state.co.us.

License Expiration Grace Period for New Applicants. All new applicants who are issued a license within 120 days of the upcoming renewal expiration date will be issued a license with the subsequent expiration date. For example, licenses issued between January 1, 2013 and April 30, 2013 will reflect a license expiration date of April 30, 2015. Licenses issued prior to January 1, 2013 will reflect an expiration date of April 30, 2013 and must renew in the upcoming renewal period.

- ▶ All Physician licenses expire on April 30 of odd-numbered years and must be renewed to continue practicing.

Checking Your Application Status. Visit Registrations Online Services at: www.doradls.state.co.us to track your application from the date we log it in our database to the date your license is printed. Please allow us enough time to receive the application through the mail and enter your application into our database before you check the website. We recommend waiting at least 10 business days from date of mailing before checking the status of your application.

APPLICANT CHECKLIST

To apply for a Pro Bono Physician License:

- Submit a completed Application for Pro Bono Physician License.** Return the completed application and all supporting documentation to the Office of Licensing.
- Enclose the non-refundable application processing fee.** See page 1 of the application form for current fees. Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to *State of Colorado*. All fees are non-refundable and subject to change every July 1.
- Complete and return the attached Affidavit of Eligibility form.** Pursuant to C.R.S. 24-34-107, all applicants for licensure are required to complete and sign an Affidavit of Eligibility, and may also be required to provide a copy of a secure and verifiable document.
- Provide documentation of any name change.** If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).
- Submit proof of one active, unrestricted physician license.**
 - ▶ Provide a detailed printout from the state's webpage verifying your license; **—OR—**
 - ▶ Request verification from the state.
- Complete and submit the Disciplinary Action Report form (Form L7 attached) directly to the Federation of State Medical Boards.** Do not send the request form to the Office of Licensing as this will delay your application processing. When the FSMB receives the request form from you, they will provide the Disciplinary Action Report directly to the Colorado Board.
 - ▶ You may also request this information through FSMB at www.fsmb.org or by phone at 1-817-571-2949.
- Complete an Online Self-Query for the National Practitioner's Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB) and submit the results.**
 - ▶ For instructions, contact NPDB-HIPDB at www.npdb-hipdb.hrsa.gov, or by phone at 1-800-767-6732.
 - ▶ Upon receipt of the results, send both reports (NPDB-HIPDB) directly to this office.
- Complete a Healthcare Professions Profile.** In compliance with the Michael Skolnik Medical Transparency Act of 2010, you are required to complete an online profile on our website at www.dora.state.co.us/hppp. You cannot start your profile until the Division of Registrations receives your application and enters it into our database. Allow 10 days from the date your application was mailed before accessing the website. If you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profiling Program at hppp@dora.state.co.us or (303) 894-5942.

Return your completed application packet and all supporting documentation to:

Division of Registrations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202



IMPORTANT NOTICE

TO: All Applicants

FROM: Rosemary McCool, Director, Division of Registrations

SUBJECT: Licensure and Criminal History

Thank you for your interest in becoming a licensed* professional within the Division of Registrations. Before you submit your application, please be aware of a few facts regarding criminal conduct, convictions, and disciplinary actions in other states.

The mission of the Division of Registrations is “public protection through effective licensure and enforcement.” One way the Division safeguards consumers is by issuing licenses to fully qualified, competent, and ethical applicants.

During the licensing process – and depending on the specific application – the Division will ask whether you have ever been disciplined in any state, arrested, charged, convicted, or pled guilty to a crime. An arrest, subsequent criminal conviction, or disciplinary action is not an automatic disqualification from licensure. Instead, the appropriate board or program will look at the facts surrounding the criminal conduct and disciplinary action to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. One thing you must do to obtain the privilege is to be completely honest on your application.

Be sure to list all relevant complaints, disciplinary actions, arrests, charges, or convictions in response to the licensure questions. Failure to fully disclose could constitute grounds alone for denial of your application or revocation of your license. More important, avoid some of the common excuses we have heard from people who failed to disclose, such as:

- My attorney told me I didn’t have to disclose the criminal conduct or disciplinary actions.
- I didn’t think the prior conduct had anything to do with the profession.
- I didn’t think the disciplinary action, arrest, charges, or conviction was still on my record.
- I didn’t think it was subject to disclosure because I received a deferred sentence/judgment.

Remember, there is no excuse not to disclose disciplinary actions and criminal conduct. Even after licensure, you are still required to notify your professional licensing board or program about subsequent convictions and disciplinary actions in other states.

The Division conducts audits of its licensing database against several criminal and national disciplinary databases. This allows the Division to verify the truthfulness of your application and track subsequent criminal and disciplinary conduct after initial licensure. Keep in mind, you will not necessarily be revoked or denied a license if you have been disciplined, arrested, charged or convicted, but you will most likely be denied or revoked if you fail to disclose it.

**The word "license" is used as a general term. While most of the professions and occupations are licensed, others may be registered, certified, or listed. For precise terminology and requirements related to a profession or occupation, please consult the [website](#) of the appropriate board or program.*



Colorado Department of Regulatory Agencies
 Division of Registrations
 1560 Broadway, Suite 1350
 Denver, CO 80202

Licensee/Applicant Full Legal Name

| Last | First | Middle | Suffix |
|------|-------|--------|--------|
| | | | |

Colorado Professional or Occupational License/Certification/Registration Number: _____
 (if already licensed)

Professional or Occupational License/Certification/Registration type applying for: _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to H.B. 06S-1009, 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.*

Section A: LAWFUL PRESENCE in the United States

1. I am a U.S. citizen. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
2. I am not a U.S. citizen, but I am lawfully present in the U.S. and authorized by the Department of Homeland Security to be employed in the U.S. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
3. I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.)
 - a. I am a U.S. citizen, not physically present or employed in the United States.
 - b. I am a Foreign National, not physically present or employed in the United States.

Section B: SECURE AND VERIFIABLE DOCUMENTS
 Select ONE document in this section if you checked 1 or 2 in Section A.

| Government Issued Identification | Name of state agency or federal agency that issued the document | Full name as shown on driver's license or state/federal issued ID | License/ID Number | Expiration Date (mm/dd/yyyy) |
|---|---|---|-------------------|------------------------------|
| <input type="checkbox"/> Driver's license or permit | | | | |
| <input type="checkbox"/> Government issued ID card | | | | |
| <input type="checkbox"/> Valid U.S. military ID/common access card | | | | |
| <input type="checkbox"/> Colorado Department of Corrections inmate ID | | | | |
| <input type="checkbox"/> Tribal ID card | | | | |
| <input type="checkbox"/> U.S. passport | | | | |
| <input type="checkbox"/> Certificate of Naturalization | | | | |

Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)

| Government Issued Identification | Name of state agency or federal agency that issued the document | Full name as shown on driver's license or state/federal issued ID | License/ID Number | Expiration Date (mm/dd/yyyy) | |
|---|--|--|---|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Certificate of (U.S.) Citizenship | | | | | |
| <input type="checkbox"/> Valid Temporary Resident card | | | | | |
| <input type="checkbox"/> Valid I-94 issued by Canadian government | | | | | |
| <input type="checkbox"/> Valid I-94 with refugee/asylum stamp | | | | | |
| <input type="checkbox"/> Valid I-766 (Employment Authorization Card) | | | Issuing federal agency: | | |
| Name on card | Alien Number (A#) | Card Number | Valid from (mm/dd/yyyy) | Expires (mm/dd/yyyy) | |
| | | | | | |
| <input type="checkbox"/> Valid I-551 (Resident Alien or Permanent Resident Card) | | | Issuing federal agency: | | |
| Name on card | Alien Number (A#) | Country of birth | Card expires (mm/dd/yyyy) | Resident since (mm/dd/yyyy) | |
| | | | | | |
| <input type="checkbox"/> Valid foreign passport with an unexpired visa with proper classification for work authorization, and an unexpired I-94 | | | | | |
| Issuing foreign country | Passport Number | Visa Number | Visa Class (ex.: J-1, P-1, H-1B, etc.) | Date of entry (mm/dd/yyyy) | Until date (mm/dd/yyyy) |
| | | | | | |
| <input type="checkbox"/> Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa | | | | | |
| Issuing foreign country: | | | Passport Number: | | |

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 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified above 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 above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Print Full Legal Name

Signature (Full Name)

Date

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to *State of Colorado*.

PART 1—APPLICANT INFORMATION

| | | | | | |
|---|--|--|---|--|----------------|
| Name: Last: | | <input type="checkbox"/> MD <input type="checkbox"/> DO | First: | Middle: | Suffix: |
| Previous Name(s): | | | | | |
| Social Security Number: * | | Date of Birth (mm/dd/yyyy): | | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Place of Birth (city and state, or foreign country): | | | | | |
| Mailing Address: | | PO Box, Street: | | | |
| This is a <input type="checkbox"/> Home <input type="checkbox"/> Business | | City, State, Zip: | | | |
| Daytime Telephone Number: () | | | E-mail Address: | | |
| | | | Preferred method for communication: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail | | |

PART 2—LICENSE INFORMATION

A. Have you ever been licensed to practice medicine in any state, territory, district, or country? (include temporary licenses and educational permits) YES NO

▶ If YES, provide a complete list of all medical licenses (if needed, attach an additional sheet in the same format):

| Type of license | State/Country | License Number | Year license issued | Disciplinary action against license? | Is this license current/active? |
|-----------------|---------------|----------------|---------------------|--|--|
| | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

B. Have you ever applied for any type of Colorado health care license prior to this application? YES NO

▶ If YES, provide application types and license information if applicable:

| Application type | License Number | Month and year license issued |
|------------------|----------------|-------------------------------|
| | | |
| | | |

***Social Security Number Disclosure:** Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in Title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's Social Security Number. Disclosure of your Social Security Number is mandatory for purposes of establishing, modifying, or enforcing child support under Sections 14-14-113 and 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by Section 26-13-107(3)(a)(1)(A), C.R.S.; and reporting to the National Practitioner Data Bank pursuant to 45 CFR Sections 60.1 et seq., and the Health Integrity and Protection Data Bank as required by 45 CFR Sections 61.1 et seq. Failure to provide your Social Security Number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your Social Security Number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your Social Security Number will not be released for any other purpose not provided for by law.

OFFICE USE ONLY

LICENSE NUMBER: _____

DATE ISSUED: _____

PART 3—SCREENING QUESTIONS

1. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic licensing board of any complaint, investigation, or inquiry which is currently pending? YES NO

▶ If YES, give details below AND request official complaint and/or investigative report be sent directly to the Board from the licensing body, as well as personally submit a narrative regarding the complaint.

| Agency | Date | Charge | Disposition |
|--------|------|--------|-------------|
| | | | |
| | | | |

2. Has any healing arts license which you now hold or have ever held 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 healthcare 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? (Disciplinary actions include, but are not limited to, 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 AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board, as well as a narrative regarding the action taken.

| Agency | Date | Charge | Disposition |
|--------|------|--------|-------------|
| | | | |
| | | | |

3. Have you ever entered into any agreement with any state, territory, district, country, U.S. government agency, and state medical/osteopathic board regarding your medical license? YES NO

▶ If YES, give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

| Agency | Date | Reason |
|--------|------|--------|
| | | |
| | | |

4. 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 AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

| Agency | Date | Reason for Denial |
|--------|------|-------------------|
| | | |
| | | |

5. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in any other state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. YES NO

▶ If YES, summarize below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

| Agency | Date | Reason |
|--------|------|--------|
| | | |
| | | |

PART 3—SCREENING QUESTIONS (Continued)

6. Have either your medical staff membership or clinical privileges at any hospital or healthcare facility or your DEA registration been voluntarily or involuntarily reduced, limited, placed on probation, not renewed or relinquished or have either been denied, revoked or suspended? You must answer YES if any of these actions are currently pending. You must answer YES if you have withdrawn or failed to proceed with an application for these items. YES NO

▶ If YES, summarize below AND request hospital or DEA to submit a report directly to the Board regarding the action. Also submit your narrative regarding the action taken.

| Name of Facility | Date | Reason for Action |
|------------------|------|-------------------|
| | | |

7. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of *nolo contendere*, or been placed on adult diversion for any violation of any law? Note: It is unnecessary to report traffic offenses that do not involve alcohol or drugs. YES NO

▶ If YES, summarize below AND submit your narrative regarding the incident as well as court and police records and information regarding final disposition of the case.

| Date | Court | Violation | Penalty or Disposition |
|------|-------|-----------|------------------------|
| | | | |

8. Do you now abuse or excessively use, or have you in the last five 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? YES NO

9. In the last five 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? YES NO

You may answer NO to Question 8 or 9 if the behavior or condition is already known to the Colorado Physician Health Program (CPHP). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment, and/or monitoring.

If you answer YES to Question 8 or 9, submit detailed information to the Board that will allow the Board to assess your ability to practice safely, competently, and without impairment to your professional judgment, skill, or knowledge. In addition to that information, you are required to provide copies of any related records, reports, evaluations, police reports, probation reports, and court records directly to the Board.

Please be advised that an affirmative response to Question 8 or 9 may result in a request from the Board for evaluation by the Colorado Physician Health Program (CPHP). The CPHP evaluation process could potentially delay consideration of an application. Therefore, the Board is providing advance notice of this possibility so that applicants may contact CPHP to schedule an evaluation at the beginning of the application process. By doing so, the application for licensure should not be unduly delayed. An applicant is not required to contact CPHP in advance of Board consideration of the application. The applicant may choose to wait for a specific decision by the Board that a CPHP evaluation is necessary. This information is being provided to put applicants on notice with respect to this potential requirement and afford the applicant the opportunity to expedite the process if he or she so desires. (Colorado Physicians Health Program – CPHP, 899 Logan Street, #410, Denver, CO 80203; 303-860-0122.)

PART 3—SCREENING QUESTIONS (Continued)

10. Within the last five years, has any final judgment, 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**, summarize below AND submit to the Board a completed malpractice Claims Information Form (attached) and a clinical narrative regarding your involvement in the case.

| Date | Name and Address of Insurance Company | Reason for Action |
|------|---------------------------------------|-------------------|
| | | |
| | | |

11. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been canceled or rated at a higher premium due to past claims experience? YES NO

▶ **If YES**, submit to the Board an explanation regarding the cancellation or increase in premiums of the insurance and verification directly from the insurance company to the Board.

PART 4—CONDITIONS OF PRO BONO PHYSICIAN LICENSURE

By checking this box, I attest that I am compliance with C.R.S. 12-36-114.3 and that:

- ▶ I do not charge for my services; except that the facility at which the services are provided may charge on a not-for-profit basis for the provision of services; or I work for and may be compensated by an organization that does not charge Colorado patients for its services.
- ▶ I have never had a license to practice medicine in this state or in another state or territory that has ever been revoked or suspended.
- ▶ I am not the subject of an unresolved complaint.
- ▶ I understand I am subject to discipline by the Board for committing unprofessional conduct, as defined in C.R.S. 12-36-117, or any other act prohibited by this article.
- ▶ I may not resume the active practice of medicine in Colorado until I fulfill reinstatement terms and receive an active license from the Colorado Medical Board.
- ▶ **I will not work more than sixty (60) days in a calendar year with a Pro Bono license.**

PART 5—SECURITY OF PATIENT MEDICAL RECORDS

By checking this box, I attest that I have developed a written plan to ensure the security of patient medical records in compliance with C.R.S. 12-36-140.

ATTESTATION

I 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), which includes state medical licensing boards and the Federation of State Medical Boards, to release to the licensing Board any information, files or records requested by the Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine during the processing of this application and the time that I am a licensee of this Board.

I state under penalty of perjury in the second degree, as defined in C.R.S. 18-8-503, that the information contained in this application is true and correct to the best of my knowledge. In accordance with C.R.S. 18-8-501(2)(a)(I), false statements made herein are punishable by law and may constitute violation of the practice act.

Signature of Applicant

Date

Colorado Division of Registrations
Office of Licensing—Medical
 1560 Broadway, Suite 1350
 Denver, CO 80202
 Phone: (303) 894-7800 / FAX: (303) 894-7693
www.dora.state.co.us/registrations

**REQUEST FOR
 FEDERATION OF STATE MEDICAL BOARDS (FSMB)—DISCIPLINARY ACTION REPORT**

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

Do not send this request form to the Colorado Office of Licensing.
When the FSMB receives the request form from you, they will provide the Disciplinary Action Report directly to the Colorado Board.

Complete this form and mail directly to:

Federation of State Medical Boards of the United States, Inc.
 400 Fuller Wiser Road, Suite 300
 Euless, TX 76039-3856

Phone: 817-868-4000
 Fax: 817-868-4099

No fee is required.

| | | | | |
|--|--|------------------------------------|----------------------------|---------|
| Physician Name: Last: | <input type="checkbox"/> MD <input type="checkbox"/> DO | First: | Middle: | Suffix: |
| Social Security Number: | | Date of Birth (mm/dd/yyyy): | | |
| Address: PO Box, Street: City, State, Zip: | | | | |
| Medical School: | | | Date of Graduation: | |

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

Colorado Division of Registrations
 Office of Licensing—Medical
 1560 Broadway, Suite 1350
 Denver, CO 80202

 Signature

 Date

**COLORADO MEDICAL BOARD
CLAIMS INFORMATION FORM**

Applicant: Complete this form for each liability or malpractice claim identified in the application Screening Question regarding malpractice.

Name of Physician Business Telephone Number

Address City, State, ZIP

1. On a separate sheet of paper, type your full name and provide a clinical narrative regarding each malpractice case(s) / allegations. Include name of patient, age, sex, date of occurrence, and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description, which includes all of the facts requested above. Simply stating that the charges were dismissed is inadequate, more detail must be provided.

2. Indicate your position in case, i.e., intern, resident, primary doctor, etc. _____

3. Case was filed against: Individual doctor Group Hospital

List names of other doctors and/or hospitals also named in the suit: _____

4. Plaintiff's Attorney and Telephone: _____

5. Is the claim pending? YES NO

6. Was there a judgment or settlement? YES NO

7. What was the amount and date of the judgment or settlement? _____

8. What amount was attributable to you, your insurance company, or your employer? _____

I certify that the information I have provided is correct to the best of my knowledge.

Signature

Date