Colorado Division of Professions and Occupations

Office of Licensing—Medical 1560 Broadway, Suite 1350

Denver, CO 80202 Phone: (303) 894-7800 / Fax: (303) 894-7693

www.dora.colorado.gov/professions

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.colorado.gov/professions/physicians.

In compliance with the Michael Skolnik Medical Transparency Act of 2010, all applicants are required to complete and maintain an online Healthcare Professions Profile on our website at www.dora.colorado.gov/professions/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.colorado.gov/professions/physicians, 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 Online Services at www.dora.colorado.gov/professions/onlineservices.

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 Online Services at www.dora.colorado.gov/professions/onlineservices 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 Colorado **Pro Bono Physician l**icense: Complete the attached application. 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. П 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 (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 (800) 767-6732. Upon receipt of the results, send both reports (NPDB-HIPDB) directly to this office. Complete an online Healthcare Professions Profile. Once your application is received and entered into the Division of Professions and Occupations database, you must create a Healthcare Professions Profile on our website at www.dora.colorado.gov/professions/hppp. You may begin checking the Healthcare Professions Profiling Program (HPPP) website within a few days of submitting your application. If you cannot create your profile within 14 days of submitting your application, or if you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profiling Program at (303) 894-5942. Your application is not considered complete, and a license will not be issued until you have submitted the online profile.

Return your completed application packet and all supporting documentation to:

Division of Professions and Occupations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202



IMPORTANT NOTICE

TO: All Applicants

FROM: Director of the Division of Professions and Occupations

SUBJECT: Licensure and Criminal History

Thank you for your interest in becoming a licensed* professional within the Division of Professions and Occupations. 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 Professions and Occupations 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 Professions and Occupations 1560 Broadway, Suite 1350 Denver, CO 80202

Licensee/Applicant Full Legal Name

Last		<u> </u>		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.								
				of the professions and occupations a profession or occupation, please co					
		Sect	ion A: LA\	WFUL PRESENCE in the Un	ited States				
1.				cceptable secure and verifiab d. Complete documentation r					
2.	to be employed	d in the U.S. Ch	neck <u>one</u> o	oresent in the U.S. and <u>authorize</u> f the acceptable secure and vicin requested. Complete doc	verifiable documents in S	ection B that			
3.	sec. 1621 (c)(2 a.	2)(a). Check one a U.S. citizen, r	e option, a one option of physica	der 8 U.S.C. sec. 1621 (c)(2)(cor b below, then skip to Section Ily present or employed in the l	C. (Do not complete Secti United States.				
	b. 📙 lam	a Foreign Nation	onal, not p	hysically present or employed	I in the United States.				
		Coot	D. CE	CUDE AND VEDICIADI E DO	CLIMENTO				
	9			CURE AND VERIFIABLE DO					
		Name of state				Expiration			
Go	vernment Issued	or federal ag	ency that	Full name as shown on o		Date			
П	Identification Driver's license or	issued the d	ocument	license or state/federal is	sued ID Number	(mm/dd/yyyy)			
	permit								
	Government issued ID card								
	Valid U.S. military ID/common access card								
	Colorado Department of Corrections inmate ID								
	Tribal ID card								
	U.S. passport								
	Certificate of								

	Section B: SECURE	AND VENILIABLE D	OCCIVILIA 13 (COI)	itiriueu <i>j</i>		
	Name of state agency				Expiration	
Government Issued	or federal agency that	Full name as sho	wn on driver's	License/ID	Date	
Identification	issued the document	license or state/fe	deral issued ID	Number	(mm/dd/yyyy)	
Certificate of (U.S.) Citizenship						
☐ Valid Temporary Resident card						
Valid I-94 issued by Canadian government						
Valid I-94 with refugee/asylum stamp						
☐ Valid I-766 (Employ	ment Authorization Card)		Issuing federal a	agency:		
Name	on card	Alien Number (A#)	Card Number	Valid from (mm/dd/yyyy)	Expires (mm/dd/yyyy)	
☐ Valid I-551 (Reside	nt Alien or Permanent Resid	dent Card)	Issuing federal a	agency:		
Name	on card	Alien Number (A#)	Country of birth	Card expires (mm/dd/yyyy)	Resident since (mm/dd/yyyy)	
		,		((**************************************	
☐ Valid foreign passp	ort with an unexpired visa w	vith proper classification	n for work authoriza	ation, and an unex	pired I-94	
			Visa Class		1	
Issuing foreign country	Passport Number	Visa Number	(ex.: J-1, P-1, H-1B, etc.)	Date of entry (mm/dd/yyyy)	Until date (mm/dd/yyyy)	
			,,	(**************************************	(**************************************	
☐ Valid foreign passport	ort bearing an unexpired "P	rocessed for I-551" sta	mp or with an attac	ched unexpired "Te	mporary I-551"	
Issuing foreign countr	y:		Passport Number	er:		
	5	Section C: ATTESTA	TION			
commercial lice am lawfully pres	at this sworn statement is re ense regulated by 8 U.S.C sent in the United States wh d to provide proof of lawful p	. sec. 1621. I understa nen asked as well as su	and that state law	requires me to pre	ovide proof that I	
are punishable	at in accordance with sect by law. I state under pena nts are true and correct.					
understand tha	n identified above and the in it under Colorado law, prov ate, registration or permit.					
 I understand the and is subject to 	at the above information mo verification.	nust be disclosed to th	e Department of R	Regulatory Agencie	es upon request	
Print Full Legal Name						
Signature (Full Name)			Date			

Application for Pro Bono License PHYSICIAN

Fee: \$164

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-	PART 1—APPLICANT INFORMATION							
Name: Last:		☐ MD ☐ DO	First:		М	iddle:		Suffix:	
Previous Name(s):									
Social Security Number	. *	Date of	Birth (r	mm/dd/yyyy):		Gender	: Male	☐ Female	
Place of Birth (city and star									
Mailing Address: This is a ☐ Home ☐ Busin	Mailing Address: PO Box, Street: This is a ☐ Home ☐ Business City, State, Zip:								
Daytime Telephone Nur	nber: ()			I Address: red method for comi	munication:	: Mail	□ E-mai	I	
	PART 2	2—LICEN	SE INF	ORMATION					
country? (include tem	icensed to practice medi porary licenses and educa	tional pern	nits)		•		☐ YES	□NO	
▶ If YES, provide a com	plete list of all medical license	s (if neede	a, attacr	▶ If YES, provide a complete list of all medical licenses (if needed, attach an additional sheet in the same format):					
Type of license	0			Voor licence	Dissipling	rv ootion	la thi	o licence	
	State/Country	License No	umber	Year license issued	Disciplina against l	ry action icense?		s license nt/active?	
	State/Country	License No	umber		Disciplina against I	ry action icense?		nt/active?	
	State/Country	License No	umber		against l	icense?	curre	nt/active?	
	State/Country	License No	umber		against I	icense?	currer	nt/active? S	
B. Have you ever applie application?	d for any type of Colorad			issued	against I	icense?	curre	nt/active? S NO S NO S NO	
application?		lo health	care lic	issued	against I	icense?	Curre	nt/active? S	
application?	d for any type of Colorad	lo health ormation if	care lic	issued	against I	Icense?	Curre	nt/active? S NO S NO S NO NO	
application? ▶ If YES, provide ap	d for any type of Colorad	lo health ormation if	care lic	issued cense prior to the	against I	Icense?	currer YE YE YE	nt/active? S NO S NO S NO NO	
application? ► If YES, provide ap	d for any type of Colorad	lo health ormation if	care lic	issued cense prior to the	against I	Icense?	currer YE YE YE	nt/active? S NO S NO S NO NO	

*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)(I)(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:

			A	PPLICANT NAME:		
		PAR	T 3—SCREENIN	G QUESTIONS		
1.	state medical/osteopar currently pending? If YES, give details bel	thic licensing board of	any complaint, in	country, U.S. government agency, or vestigation, or inquiry which is ative report be sent directly to the Board from e complaint.	☐ YES	□NO
	Agency	Date	Charge	Dispos	sition	
2.	censured and/or discippeer review committee or medical society or a enforcement agency of allegations currently problems of the properties of the problems of	plined in any way by are or body, by any healt association or committed rourt of law? (Disciplending.) Washington lie to this question.	ny licensing agen hcare facility or c ee thereof, or by a inary actions incl censees must dis disciplinary document	r held been admonished, reprimanded, cy in another state or country, by any committee thereof, by any professional any governmental agency, law ude, but are not limited to, any sclose any Stipulation to Informal s including initial complaint, stipulations, orders ding the action taken.	☐ YES	□NO
	Agency	Date	Charge	Dispos	sition	
3.	government agency, a If YES, give details bel	nd state medical/osted	ppathic board reg disciplinary documents ubmit your narrative r	ritory, district, country, U.S. arding your medical license? s including initial complaint, stipulations, orders egarding the action taken. Reason	☐ YES	□ NO

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? ▶ 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.		☐ YES	□NO	
_	Agency	Date	Reason		
4.			actice medicine or any other healing art, or /, or U.S. federal jurisdiction?	☐ YES	□NO
			ocuments including initial complaint, stipulations, orders, ubmit your narrative regarding the action taken.		
	Agency	Date	Reason for Denial		
5.		. federal jurisdiction? This de	ctice medicine or any other healing arts in any oes not include allowing your license to	☐ YES	□NO
	► If YES, summarize below AN	ND request all official disciplinary do	ocuments including initial complaint, stipulations, orders, ubmit your narrative regarding the action taken.		
	Agency	Date	<u>Reason</u>		

			APPLICANT NAME	i:		
		PART 3—SCREENIN	IG QUESTIONS (Cor	ntinued)		
6.	Have either your medical staff me or your DEA registration been vo renewed or relinquished or have if any of these actions are curren to proceed with an application for If YES, summarize below AND requirements.	luntarily or involuntari either been denied, re tly pending. You must these items.	ly reduced, limited, pla evoked or suspended answer YES if you h	aced on probation, not? You must answer YES ave withdrawn or failed	YES	□NO
	submit your narrative regarding the	action taken.	,	3		
	Name of Facility	Date	Reason for Action	on_		
7.	Have you ever been charged, income deferred judgment and sentence, been placed on adult diversion for offenses that do <u>not</u> involve alcohol information regarding final disposition	, entered a plea of gui or any violation of any nol or drugs. nit your narrative regarding	Ity, entered a plea of law? Note: It is unner	nolo contendere, or cessary to report traffic	☐ YES	□NO
	Date Court		Violation	Penalty or Di	sposition	
8.	Do you now abuse or excessively used, any habit forming drug, inc any accusation or discipline for m professional responsibilities; or b competently?	luding alcohol, or any nisconduct, unreliabilit	controlled substance y, neglect of work, or	that has a) resulted in failure to meet	YES	□NO
9.	In the last five years, have you be disturbs your cognition, behavior, physician safely and competently depression, schizophrenia or othe disorder?	, or motor function, an rincluding but not limi	id that may impair you ted to bipolar disorde	r ability to practice as a r, severe major	☐ YES	□NO
"Kn	n may answer NO to Question 8 or 9 if own to CPHP" means that you have in uirements for evaluation, treatment, an	nformed CPHP of your b				CPHP).
saf	ou answer YES to Question 8 or 9, sely, competently, and without impairmaired to provide copies of any related and.	ent to your professional	judgment, skill, or know	ledge. In addition to that info	rmation, you	are
The beg	ase be advised that an affirmative representation or ado Physician Health Program (Corefore, the Board is providing advance inning of the application process. By a tact CPHP in advance of Board consider a CPHP evaluation is necessary. This uirement and afford the applicant the CPHP, 899 Logan Street, #410, Denve	CPHP). The CPHP evalue notice of this possibility doing so, the application deration of the application information is being propportunity to expedite to	nation process could pot y so that applicants may for licensure should not on. The applicant may cl rovided to put applicants he process if he or she	entially delay consideration of contact CPHP to schedule to be unduly delayed. An applenoose to wait for a specific do notice with respect to this	of an application of an evaluation icant is not recision by the spotential	tion. n at the equired to e Board

			APPLICANT NAME	<u> </u>		
		PART 3—SCREENING	QUESTIONS (Cor	ntinued)		
		e last five years, has any final judgment, settleme ice been paid on your behalf or has any claim be	ent or arbitration av	ward for medical	☐ YES	□NO
.	If YE	s, summarize below AND submit to the Board a completed mal narrative regarding your involvement in the case.				
-	Dat	e Name and Address of Insurance	ce Company	Reason for Action		
		u ever been refused malpractice insurance, or ha		insurance ever been	☐ YES	□NO
•		ES , submit to the Board an explanation regarding the cancella ication directly from the insurance company to the Board.	tion or increase in pren	niums of the insurance and		
		PART 4—CONDITIONS OF PRO				
	Ву	checking this box, I attest that I am compliance	e with C.R.S. 12-3	6-114.3 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 is revoked or suspended.	n this state or in ar	nother state or territory th	nat has ever	been
	>	I am not the subject of an unresolved complaint.				
	>	I understand I am subject to discipline by the Boa 12-36-117, or any other act prohibited by this arti		unprofessional conduct,	as defined i	n C.R.S.
	>	I may not resume the active practice of medicine active license from the Colorado Medical Board.	in Colorado until I	fulfill reinstatement term	s and receiv	/e an
	>	I will not work more than sixty (60) days in a d	alendar year wit	h a Pro Bono license.		
Are veu			-MILITARY			
Are you	aw	ember of the U.S. military?			☐ YES	□NO
	>	If YES, provide information below:				
Branch:	i		Duty Station:			
		PART 6—SECURITY OF PA	ATIENT MEDICAL	. RECORDS		
	Bv	checking this box, I attest that I have developed a			ent medical r	ecords
_		compliance with C.R.S. 12-36-140.	pian to on	is and deducting or putte		

ATTESTATION	
I hereby make application for a license to practice medicine in the institutions or organizations, my references, personal physicians associations (past and present), and all government agencies (I licensing boards and the Federation of State Medical Boards, to records requested by the Board in connection with the processing to the organizations, individuals and groups listed above any infing practice of medicine during the processing of this application.	s, employers (past and present), business and professional ocal, state, federal and foreign), which includes state medical release to the licensing Board any information, files or ng of this application. I further authorize this Board to release formation which is material to my application or pertinent to
I state under penalty of perjury in the second degree, as det this application is true and correct to the best of my knowle statements made herein are punishable by law and may con	dge. In accordance with C.R.S. 18-8-501(2)(a)(I), false
Applicant Signature	Date

APPLICANT NAME: _

Colorado Division of Professions and Occupations Office of Licensing—Medical

1560 Broadway, Suite 1350 Denver, CO 80202

Phone: (303) 894-7800 / Fax: (303) 894-7693 www.dora.colorado.gov/professions

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 N	Name: Last:	☐ MD	First:		Middle:	Suffix:	
Social Security Number:			Date of Birth (mm/dd/yyyy):				
Address:	PO Box, Street: City, State, Zip:		,				
Medical Scl	hool:		Date of Graduation:				
I hereby authorize and request that the Federation of State Medica history to the following: Colorado Division of Professions and Occupations Office of Licensing—Medical 1560 Broadway, Suite 1350 Denver, CO 80202				s of the United Sta	ates, Inc. provide a	a disciplinary	
Signature			<u>_</u>	Date			

10/2012 **L7**

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. List names of other doctors and/or hospitals also named in the suit: 4. Plaintiff's Attorney and Telephone: \square NO 5. Is the claim pending? ☐ YES 6. Was there a judgment or settlement? ☐ YES \square 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