

EFFECTIVE AS A FINAL ORDER

DATE: 8.26.20

FILED
AUG 07 2020
KS State Board of Healing Arts

**BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS**

In the Matter of

**Steven B. Bleyl, M.D.
Kansas License No. 04-41987**

Docket No. 21-HA 00015

SUMMARY ORDER

NOW ON THIS 7th day of August 2020, this matter comes before Tucker L. Poling, Acting Executive Director, Kansas State Board of Healing Arts ("Board"), in summary proceedings pursuant to K.S.A. 77-537.

Pursuant to K.S.A 77-537 and K.S.A. 77-542, this Summary Order shall become effective as a Final Order, without further notice, if no written request for a hearing is made within 15 days of service. Upon review of the agency record and being duly advised in the premises, the following findings of fact, conclusions of law, and order are made for and on behalf of the Board:

Findings of Fact

1. Steven B. Bleyl, M.D. ("Licensee") was issued License No. 04-41987 to practice medicine and surgery on April 1, 2019. On or about July 9, 2020, Licensee renewed his license status as Active.
2. Licensee's last known mailing address to the Board is: CONFIDENTIAL
CONFIDENTIAL
3. During all times relevant to the facts set forth in this Summary Order, Licensee held an Active license to practice medicine and surgery in Kansas.
4. The factual basis for this Order is as follows:

**Summary Order
Steven B. Bleyl, M.D.**

- a. On or about April 1, 2019, Licensee applied for an Active license by and through an Application For Medical Licenses In IMLC Member States. Licensee's application stated that "I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses I hold." Licensee signed and acknowledged this statement. (Exhibit 1.)
- b. In a Letter of Qualification sent to Licensee, Licensee was told, "You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions." (emphasis in original). Licensee received this notice in his Letter of Qualification. (Exhibit 2.)
- c. After he had been granted an Active license, a search of the Kansas Healthcare Stabilization Fund ("KHCSF") showed that Licensee was not in compliance.
- d. On September 16, 2019, and October 18, 2019, the Board requested Licensee to provide proof of compliance with the Kansas Health Care Stabilization Fund ("KHCSF"), as required by K.S.A. 40-3404. The Board included instructions on how to contact KHCSF and warned that a failure to provide proof of compliance may result in a fine or suspension of Licensee's license to practice medicine in Kansas. (Exhibit 3 and 4.)

- e. On or about November 7, 2019, after receiving no response to the September 16, 2019, and October 18, 2019, letters, the matter was referred to the Litigation Department.
- f. On or about November 20, 2019, Licensee came into compliance with the Fund. (Exhibit 5.)
- g. Licensee was out of compliance with the KHCSF between on or about April 1, 2019, until at least November 20, 2019, while holding an Active license to practice medicine and surgery in Kansas. (*Id.*)

Applicable Law

5. Under the Kansas Healing Arts Act, K.S.A. 65-2809(c),

The board, prior to renewal of a license, shall require an active licensee to submit to the board evidence satisfactory to the board that licensee is maintaining a policy of professional liability insurance as required by K.S.A. 40-3402, and amendments there to, and has paid the premium surcharges as required by K.S.A. 40-3404, and amendments thereto.

6. K.S.A. 40-3402 states:

(a) A policy of professional liability insurance approved by the commissioner and issued by an insurer duly authorized to transact business in this state in which the limit of the insurer's liability is not less than \$200,000 per claim, subject to not less than a \$600,000 annual aggregate for all claims made during the policy period, shall be maintained in effect by each resident health care provider as a condition of active licensure or other statutory authorization to render professional service as a health care provider in this state, unless such health care provider is a self-insurer. . .

(b) A nonresident health care provider shall not be licensed to actively render professional service as a health care provider in this state unless such health care provider maintains continuous coverage in effect as prescribed by subsection (a), except such coverage may be provided by a non-admitted insurer who has filed the form required by subsection (b)(1). This provision shall not apply to optometrists and pharmacists on or after July 1, 1991 nor to physical therapists on and after July 1, 1995.

(1) Every insurance company authorized to transact business in this state, that is authorized to issue professional liability insurance in any jurisdiction, shall file with the commissioner, as a condition of its continued transaction of business within this state, a form prescribed by the commissioner declaring that its professional liability insurance policies, wherever issued, shall be deemed to provide at least the insurance required by this subsection when the insured is rendering professional services as a nonresident health care provider in this state. Any nonadmitted insurer may file such a form.

(2) Every nonresident health care provider who is required to maintain basic coverage pursuant to this subsection shall pay the surcharge levied by the board of governors pursuant to subsection (a) of K.S.A. 40-3404 and amendments thereto directly to the board of governors and shall furnish to the board of governors the information required in subsection (a)(1). . .

7. K.S.A. 40-3404 states:

(a) Except for any health care provider whose participation in the fund has been terminated pursuant to subsection (i) of K.S.A. 40-3403, and amendments thereto, the board of governors shall levy an annual premium surcharge on each health care provider who has obtained basic coverage and upon each self-insurer for each year.

(b) In the case of a resident health care provider who is not a self-insurer, the premium surcharge shall be collected in addition to the annual premium for the basic coverage by the insurer and shall not be subject to the provisions of K.S.A. 40-252, 40-955 and 40-2801 et seq., and amendments thereto. The amount of the premium surcharge shall be shown separately on the policy or an endorsement thereto and shall be specifically identified as such. Such premium surcharge shall be due and payable by the insurer to the board of governors within 30 days after the annual premium for the basic coverage is received by the insurer. Within 15 days immediately following the effective date of this act, the board of governors shall send to each insurer information necessary for their compliance with this subsection. The certificate of authority of any insurer who fails to comply with the provisions of this subsection shall be suspended pursuant to K.S.A. 40-222, and amendments thereto, until such insurer shall pay the annual premium surcharge due and payable to the board of governors. In the case of a nonresident health care provider or a self-insurer, the premium surcharge shall be paid upon submitting documentation of compliance with K.S.A. 40-3402, and amendments thereto.

8. Under K.S.A. 65-2836, a license may be revoked, suspended or limited, or the licensee may be publicly censured or placed under probationary conditions, upon a finding of the existence of any of the following grounds:

(z) The licensee has failed to pay the premium surcharges as required by K.S.A. 40-3404.

Conclusions of Law

9. The Board has jurisdiction over Licensee as well as the subject matter of this proceeding, and such proceeding is held in the public interest.

10. The Board finds that Licensee violated K.S.A. 65-2836(z), in that Licensee has failed to pay the premium surcharges as required by K.S.A. 40-3404.

11. Based on the facts and circumstances set forth herein, the use of summary proceedings in this matter is appropriate, in accordance with the provisions set forth in K.S.A. 77-537(a), in that the use of summary proceedings does not violate any provision of law, and the protection of the public interest does not require the Board to give notice and opportunity to participate to persons other than Licensee.

IT IS HEREBY ORDERED that a **PUBLIC CENSURE** shall be issued against Licensee, and that Licensee is assessed a **CIVIL FINE** in the amount of five hundred dollars (**\$500.00**) for violations of the Kansas Healing Arts Act, due within thirty (30) days after this Order becomes a Final Order. Such fine shall be paid to the "Kansas State Board of Healing Arts," in full. All monetary payments, which shall be in the form of check or money order, relating to this Summary Order shall be mailed to the Board certified and addressed to:

Compliance Coordinator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level – Suite A
Topeka, Kansas 66612
KSBHA_ComplianceCoordinator@ks.gov

Summary Order
Steven B. Bleyl, M.D.

PLEASE TAKE NOTICE that upon becoming effective as a Final Order, this document shall be deemed a public record and be reported to any reporting entities authorized to receive such disclosure.

Dated this 7th day of August 2020.

KANSAS STATE BOARD
OF HEALING ARTS



Tucker L. Poling
Acting Executive Director

FINAL ORDER NOTICE OF RIGHTS

PLEASE TAKE NOTICE that this is a Final Order. A Final Order is effective upon service. A party to an agency proceeding may seek judicial review of a Final Order by filing a petition in the District Court as authorized by K.S.A. 77-601, *et seq.* Reconsideration of a Final Order is not a prerequisite to judicial review. A petition for judicial review is not timely unless filed within 30 days following service of the Final Order. A copy of any petition for judicial review must be served upon Tucker L. Poling, Acting Executive Director, Kansas Board of Healing Arts, 800 SW Jackson, Lower Level-Suite A, Topeka, KS 66612.

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that a true copy of the foregoing **FINAL ORDER** was served this 26th day of August 2020 by depositing the same in the United States Mail, first-class, postage prepaid, and addressed to:

Steven B. Bleyl, M.D.
CONFIDENTIAL

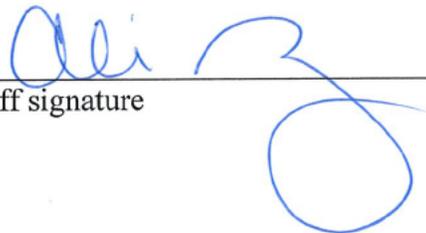
Licensee

And a copy was hand-delivered to:

Tammie L. Mundil
Deputy Litigation Counsel
Meg D. Markey
Associate Litigation Counsel
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

Compliance Coordinator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level - Suite A
Topeka, Kansas 66612

And the original was filed with the office of the Executive Director.



Staff signature

QUALIFICATIONS APPLICATION

If you do not complete the application process you will be sent an email with a link to log back in to complete the documents. Be sure to look in your SPAM and JUNK folders. To apply for a Letter of Qualification for licensure through the Interstate Medical Licensure Compact please answer the questions below.

IS THIS A RE-APPLICATION(earned an LOQ in the past and now is reapplying)? YES NO

1. Which IMLC Member State do you want to serve as your State of Principal License (SPL)?:
UTAH M.D.

2. Do you hold a full and unrestricted medical license to engage issued by a medical licensing board in the SPL (SPL Board) UTAH PHYSICIANS & SURGEONS LICENSING BOARD ? Yes No

3. What is the license number issued to you by the SPL board? 5400608-1205

4. Which of the following apply to you(at least one must apply)?

a. Your primary residence is in the SPL UTAH M.D. : Yes No

If yes, provide the following:

Residence Street address CONFIDENTIAL

Residence City State Zip _____
City St Zip

b. At least 25% of your practice of medicine occurs in the SPL UTAH M.D. Yes No

If yes, describe your current practice _____

c. Your employer is located in the SPL UTAH M.D. : Yes No

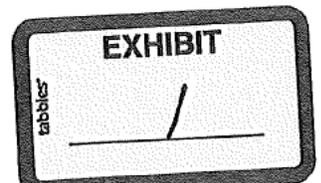
If Yes, Employer name _____

Employer street address _____

Employer City State Zip _____
City St Zip

d. You have designated the SPL UTAH M.D. as your state of residence for U.S. federal income tax purposes: Yes No

If yes, give Tax ID # (SS#, EIN) CONFIDENTIAL (must be most recent return)



5. Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes No

6. Have you passed each component of the United State Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes(if in question contact your SPL)? Yes No

7. Have you successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association? Yes No

8. Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? Yes No

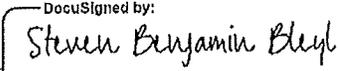
(Please note that answering any of the following questions with a "YES" will result in your application being denied per eligibility Rule 5.4. If eligibility is in question please contact the state board directly for information regarding application through the traditional method.)

9. Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? Yes No

10. Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? Yes No

11. Have you ever had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? Yes No

12. Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? Yes No

Physician's Signature: 
Type Name: Steven B. Bleyl
Date: 10/5/2018 | 5:39 CDT

**AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR AN
IMLC LETTER OF QUALIFICATION AND MEDICAL LICENSES IN IMLC MEMBER STATES**

I, Steven Benjamin Bleyl (Type in full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as my being prosecuted under appropriate federal and state laws.

I hereby apply to UTAH M.D. as my State of Principal License ("SPL") for a Letter of Qualification ("LOQ") to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I hereby authorize and request every person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the SPL any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the SPL or any of its agents or representatives to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact.

I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the SPL.

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application, and further authorize the SPL to process my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a Letter of Qualification, and revocation, or other disciplinary sanction, of my license(s) or permit(s) to practice medicine in one or more Compact Member States.

Applicant Signature DocuSigned by: Steven Benjamin Bleyl
18937EDCD87B449...

Type Applicant's Name Steven B. Bleyl

Applicant's NPI 1467405407

DATE 10/5/2018 | 5:39 CDT

In Process

PHYSICIAN'S CORE DATA SHEET

(Must be the physician's accurate information to avoid delay or rejection)

Full Legal Name Steven, Benjamin, Bleyl
(Exactly as on DL or Passport) First Middle Last Suffix(Sr., Jr.)

Other names used(maiden, birth) _____
First Middle Last

Mailing address _____ **CONFIDENTIAL**
Mailing address City State(XX) Zip

Office address 2150 S. 1300 E, suite 500, Salt Lake City, UT, 84106
Office address City State(XX) Zip

Date of Birth **CONFIDENTIAL** _____ Gender: Male Female
(mm/dd/yyyy)

Physician's office or practice telephone number of public record 385-419-0956
(###-###-####)

Physician's cellular or alternative telephone number **CONFIDENTIAL** _____
(###-###-####)

Email address delegated by applicant to receive correspondence steve@genomemeda1.com

Social Security Number: **CONFIDENTIAL** _____
(###-##-####)

Physician's National Provider Identifier Number 1467405407

Medical Degree Received: M.D. D.O.

(Medical school must be accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or be listed in the International Medical Education Directory or its equivalent.)

Medical School University of Utah School of Medicine
Name of School (no abbreviations or acronyms)

Date of Degree Issued 05/20/2000
(mm/dd/yyyy)

Physicians must have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. (NOTE: One-year transitional residencies do not meet this requirement)

Residency Program University of Arizona College of Medicine Completion Date 06/30/2003
Full Program Name (no abbreviations or acronyms) (mm/dd/yyyy)

What is the specialty of the program Pediatrics

Qualifying Licensing exam taken: USMLE COMLEX Other _____
Must specify by name

Number of attempts taken to pass the USMLE:

Step 1: 1 Step 2 CS: 1 Step 2 CK: 1 Step 3: 1

Number of attempts taken to pass the COMLEX:

Step 1: _____ Step 2 PE: _____ Step 2 CE: _____ Step 3: _____

Number of attempts taken to pass other licensing exam:

Step 1: _____ Step 2: _____ Step 3: _____

Specialty Board Certification must be by an ABMS or AOABOS board.

Specialty Board Certification: American Board of Medical Genetics and Genomics
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

Lifetime:

Time limited: Expiration date of time limited 12/31/2027
(mm/dd/yyyy)

Physicians must possess a full and unrestricted medical license issued by an IMLC Member Board.

License # 5400608-1205 Date of Original License 10/29/2003 (not renewal)
(mm/dd/yyyy)

Expiration Date 01/31/2020 Status of License: Current: Not Current:
(mm/dd/yyyy)

Thank you for applying through the Interstate Medical Licensure Compact.

*The state will contact you to give instructions on obtaining your fingerprints for a criminal background check. **YOU HAVE 60 DAYS TO COMPLY WITH REQUESTS FROM THE STATE** to avoid automatic withdraw. Background checks may take some time, so please be patient. If you have any concerns contact your SPL. SPL contact numbers can be found at www.IMLCC.org. You will receive an email regarding the status of your qualification. Be sure to check your spam folder and set your email to accept messages from the @docusign.net and @docusign.com domains.*

FOR USE OF STATE OF PRINCIPAL LICENSE

I have conducted the verification process of this physician's application.

State Authorized Signature _____

DocuSigned by:

UTAH PHYSICIANS & SURGEONS I

09599FB82B8A4DC...

Elizabeth Sorenson

Type Name _____

Warning: The signature tab will default to your Board's name. Please change it to your name in Adopt and Sign.

Title Licensing Specialist

CORE DATA CORRECTION SHEET

To process corrections please use the below freeform text boxes. The corrections will be passed to the Member Boards selected to issue licenses. If you use this sheet there is no need to send any correction emails.

Core Data to be changed	Incorrect data	Correction
USMLE Step 2 CS	1	0

In Progress

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name _____
First Name Middle Name Last Name

Please fill in your respective Member Board's information for the qualified Physician named above.

National Provider Identifier Number _____

Medical Board Name _____

Member Board License Number _____

Date License Issued _____
mm/dd/yyyy

Date of Expiration _____
mm/dd/yyyy

Warning: The signature tab will default to your Board's name. Please change it to your name in Adopt and Sign

Member Board Signature _____

Type Name _____

DATE _____

Letter of Qualification

IS THIS A RE-APPLICATION? YES NO

Date 11/08/2018
mm/dd/yyyy

Name: Steven Benjamin Bleyl

CONFIDENTIAL

Address: _____

CityStZip _____

Dear Dr. Bleyl:

RE: Your application for IMLC Letter of Qualification

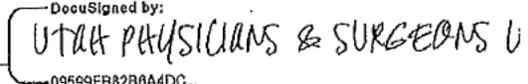
The UTAH PHYSICIANS & SURGEONS LICENSING BOARD

("Board"), on behalf of the State of Principal Licensure ("SPL") you selected, has received and reviewed your application for a Letter of Qualification ("LOQ") for licensure through the Interstate Medical Licensure Compact ("IMLC").

Based upon the information you submitted with your application, data in the Board's files regarding your licensure by the Board, verifications of your credentials, and the results of the check of national databases, the Board has determined that you are ELIGIBLE to be licensed through the IMLC. Therefore, this notice will serve as your LOQ for licensure in IMLC Member States through the IMLC, and will remain in effect for 365 days from date of issuance, set out above.

An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license in by each.

All medical licenses issued by Member Boards through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions including, but not limited to, each Member Board's continuing medical education requirements. It is also your obligation to keep your SPL, the Member Boards which have licensed you, and the IMLC Commission informed of any changes in your contact information or qualifications and eligibility for licensure through the IMLC.

Authorized Signature from SPL 

Type Name Elizabeth Sorenson

Title of Authorized SPL Licensing specialist

DATE 11/8/2018 | 3:06 CST



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
3/13/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

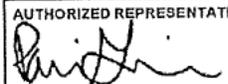
PRODUCER Woodruff-Sawyer & Co. 50 California Street, Floor 12 San Francisco CA 94111	CONTACT NAME: PHONE (A/C No, Ext): 415-391-2141 E-MAIL ADDRESS:	FAX (A/C No): 415-989-9923
	INSURER(S) AFFORDING COVERAGE	
INSURED GENOMED-01 Genome Medical, Inc. Genome Medical Holding 701 Gateway Blvd., #380 South San Francisco CA 94080	INSURER A: Chubb Custom Insurance Company NAIC #: 38989	
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** 829942349 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$ PER STATUTE OTH-ER
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Healthcare Professional Liability - Deductible			CONFID	10/20/2018	10/20/2019	Each Wrongful Act: \$1,000,000 Each Event: \$50,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Includes coverage for (Steve Bley) on behalf of Genome Medical Services.

CERTIFICATE HOLDER Genome Medical Services 701 Gateway Blvd., #380 South San Francisco CA 94080	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE 

APPLICATION FOR RENEWAL OF MEDICAL LICENSE IN AN
IMLC MEMBER STATE THROUGH THE IMLC
FOR KANSAS BOARD OF HEALING ARTS

PAID 425.00

To renew a medical license issued by a Member State of the Interstate Medical Licensure Compact (IMLC), please answer the questions below:

[IMPORTANT NOTE: The physician holding the medical license being renewed **must** be the person answering these questions, as they are attested to under penalty of perjury.]

1. What is your National Provider Identifier (NPI) number? 1467405407

2. What is your name? Steven Benjamin Bleyl
First name Middle name Last name

3. You have indicated you are using the following Board for your State of Principal License:
UTAH PHYSICIANS & SURGEONS LICENSING BOARD

Is your license issued by that SPL currently full and unrestricted? Yes No

What is the number of that medical license? 5400608-1205

4. You have indicated you wish to renew the license issued to you by the
KANSAS BOARD OF HEALING ARTS

What is the number of that medical license you wish to renew? 04-41987

5. Have you been convicted, or received adjudication, deferred adjudication, community supervision, or deferred disposition, for any criminal offense by a court? Yes No

6. Have you had a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction (excluding any action related to the non-payment of fees related to a license? Yes No

7. Have you had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? Yes No

8. Have you complied with all continuing professional development or continuing medical education requirements to renew in KANSAS? Yes No

DocuSigned by:
Applicant's signature Steven Benjamin Bleyl
18937EDCC087B449...
Applicant's name Steven B. Bleyl

Date 7/11/2019 | 10:54 CDT

ATTESTATION

I, Steven B Bleyl the undersigned, hereby attest and certify that I am the person named in this APPLICATION FOR RENEWAL OF MEDICAL LICENSE IN AN IMLC MEMBER STATE THROUGH THE IMLC ("Renewal Application") that I have submitted, that all statements I have made or shall make with respect thereto are true, and that all statements, representations, documents, forms, or copies thereof furnished or to be furnished with respect to my Renewal Application are strictly true in every aspect.

I hereby apply to the KANSAS BOARD OF HEALING ARTS ("Member Board") and further authorize the Member Board to process my Renewal Application for renewal of medical licensure by the Member Board, and I hereby release, discharge, and exonerate the Member Board, the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind arising out of any disclosure to the Member Board.

I acknowledge that I have read, understand and answered all questions contained in the Renewal Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to a refusal to renew a medical license or permit, or disciplinary action against one or more medical licenses or permits I hold, as well as my being prosecuted under appropriate federal and state laws.

I understand and acknowledge that the Member Board may require submission of information in addition that provided with this Renewal Application; that I am required to comply with all of the Member Board's continuing professional development or medical education requirements; and, that my failure to submit such information to the Member Board, or to comply with the Member Board's continuing professional development or medical education requirements, may constitute grounds for revocation of, or other disciplinary action against, the medical license issued to me and renewed by the Member Board in response to this Renewal Application.

I hereby release, discharge, and exonerate the SPL, the Member Board, and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the SPL or the Member Board.

I will immediately notify the SPL, the Member Board, and the Commission in writing of any changes to the answers to any of the questions contained in the Renewal Application if such a change occurs at any time prior to a medical license being renewed by the Member Board.

I understand my failure to answer questions contained in the Renewal Application truthfully and completely may lead to denial of my renewal of a medical license in the Member Board, and revocation of, or other disciplinary action against, my license(s) or permit(s) to practice medicine in one or more Compact Member States.

Applicant's signature 
Applicant's name Steven B Bleyl

DocuSigned by:
18937EDCD87B449...

Applicant's National Provider Identifier (NPI) number 1467405407

Date 7/11/2019 | 10:54 CDT

MEDICAL LICENSE RENEWAL INFORMATION

Physician's Name Steven Benjamin Bleyl

Please fill in your respective Member Board's information for the qualified Physician named above.

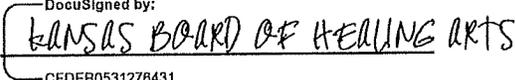
Personal National Provider Identifier Number 1467405407

Medical Board Name: KANSAS BOARD OF HEALING ARTS

Member Board Renewal License Number 04-41987

Date Renewal Issued 07/11/2019
mm/dd/yyyy

Date Renewal Expired 07/31/2020
mm/dd/yyyy

Member Board Signature 
Type Name Ronda Bohannon
Date 7/11/2019 | 12:42 CDT

Letter of Qualification

IS THIS A RE-APPLICATION? YES NO

Date 11/08/2018
mm/dd/yyyy

Name: Steven Benjamin Bleyl

Address: CONFIDENTIAL

CityStZip _____

Dear Dr. Bleyl:

RE: Your application for IMLC Letter of Qualification

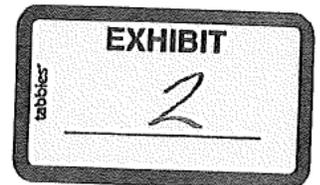
The UTAH PHYSICIANS & SURGEONS LICENSING BOARD ("Board"), on behalf of the State of Principal Licensure ("SPL") you selected, has received and reviewed your application for a Letter of Qualification ("LOQ") for licensure through the Interstate Medical Licensure Compact ("IMLC").

Based upon the information you submitted with your application, data in the Board's files regarding your licensure by the Board, verifications of your credentials, and the results of the check of national databases, the Board has determined that you are ELIGIBLE to be licensed through the IMLC. Therefore, this notice will serve as your LOQ for licensure in IMLC Member States through the IMLC, and will remain in effect for 365 days from date of issuance, set out above.

An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license in by each.

All medical licenses issued by Member Boards through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions including, but not limited to, each Member Board's continuing medical education requirements. It is also your obligation to keep your SPL, the Member Boards which have licensed you, and the IMLC Commission informed of any changes in your contact information or qualifications and eligibility for licensure through the IMLC.

Authorized Signature from SPL UTAH PHYSICIANS & SURGEONS L
Type Name Elizabeth Sorenson
Title of Authorized SPL Licensing Specialist
DATE 11/8/2018 | 3:06 CST



Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612



phone: 785-296-7413
fax: 785-368-7102
Email: KSBHA_healingarts@ks.gov
www.ksbha.org

Kathleen Selzler Lippert, Executive Director

Laura Kelly, Governor

September 16, 2019

1423321
Steven Benjamin Bleyl, MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; 04-41987

Dear Dr. Bleyl:

Under the Kansas State Board of Healing Arts ("Board") audit process, you have been selected to provide proof of your professional liability insurance and Kansas Health Care Stabilization Fund ("KHCSF") compliance for your most recent renewal period.

In Kansas, if you have an Active license, you are required to maintain professional liability insurance of not less than \$200,000 per claim, and not less than \$600,000 annual aggregate for all claims made during the policy period. *See* K.S.A. 40-3402(a)-(b); K.S.A. 65-2809(c). Additionally, you are required to maintain compliance with the KHCSF by paying the annual surcharge. *See* K.S.A. 40-3402; K.S.A. 40-3404; and K.S.A. 65-2809(c).

According to the Board's records, you most recently renewed your license for the period of August 1, 2019, through July 31, 2010. On that renewal, you agreed to maintain and produce proof of professional liability insurance and KHCSF compliance upon request. *See generally* K.S.A. 65-2809(c).

Please provide proof of your: (1) professional liability insurance; and (2) KHCSF compliance for the period for which you renewed your license, on or before **October 16, 2019**. Failure to produce this requested information may result in disciplinary action against your license, including but not limited to, a fine, a public censure, and/or **SUSPENSION** of your license. Submit all proof via email to KSBHA_Licensing@ks.gov.

To effectuate submission of evidence of KHCSF compliance to the Board, you must contact the KHCSF and obtain a certification that you have paid the annual premium charges. You must then submit a copy of the certification to the Board. Please keep in mind, if you are a non-resident, you must also submit a non-resident form to the KHCSF.

If you have questions about submitting forms to or compliance with the KHCSF, you can contact the KHSCF by mail, telephone, or email at the following:

BOARD MEMBERS: STEVEN J. GOULD, PRESIDENT, CHENEY • JOHN F. SETTICH, PH.D., PUBLIC MEMBER, VICE PRESIDENT, ATCHISON • MARK BALDERSTON, DC, SHAWNEE
R. JERRY DEGRADO, DC, WICHITA • ROBIN D. DURRETT, DO, GREAT BEND • THOMAS ESTEP, MD, WICHITA • ANNE HODGDON, PUBLIC MEMBER, LENEXA
JOEL R. HUTCHINS, MD, HOLTON • STEVE KELLY, PUBLIC MEMBER, NEWTON • DAVID LAHA, DPM, OVERLAND PARK • DOUGLAS J. MILFELD, MD, WICHITA
GAROLD O. MINNS, MD, BEL AIRE • KIMBERLY J. TEMPLETON, MD, LEAWOOD • RONALD M. VARNER, DO, EL DORADO

TTY (HEARING IMPAIRED) 711 OR 1.800.765.3777 VOICE/TTY • E-MAIL: KSBHA_HEALINGARTS@KS.GOV



Kansas Health Care Stabilization Fund
300 SW 8th Ave, 2nd FL
Topeka, KS 66603
(785) 291-3777
www.hcsf.org

All the KHCSF's forms are available at: <https://hcsf.kansas.gov/forms/>

If you currently hold an Active license in Kansas, but do not actively practice in Kansas, you may want to consider changing your license status to either Exempt or Inactive. To change your license status, please submit an Application for Change of Designation/Type.

All correspondence regarding your professional liability insurance and KHCSF compliance audit must be directed to: KSBHA_Licensing@ks.gov, or via mail:

Kansas State Board of Healing Arts
Attn: MD Audit
800 SW Jackson, Lower Level – Suite A
Topeka, KS 66612

Sincerely,

Rebekah Moon

Licensing Administrator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level – Suite A
Topeka, Kansas 66612

BOARD MEMBERS: STEVEN J. GOULD, PRESIDENT, CHENEY • JOHN F. SETTICH, PH.D., PUBLIC MEMBER, VICE PRESIDENT, ATCHISON • MARK BALDERSTON, DC, SHAWNEE
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JOEL R. HUTCHINS, MD, HOLTON • STEVE KELLY, PUBLIC MEMBER, NEWTON • DAVID LAHA, DPM, OVERLAND PARK • DOUGLAS J. MILFELD, MD, WICHITA
GAROLD O. MINNS, MD, BEL AIRE • KIMBERLY J. TEMPLETON, MD, LEAWOOD • RONALD M. VARNER, DO, EL DORADO

TTY (HEARING IMPAIRED) 711 OR 1.800.766.3777 VOICE/TTY • E-MAIL: KSBHA_HEALINGARTS@KS.GOV

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612
Tucker Poling, Interim Executive
Director



PHONE: 785-296-7413
FAX: 785-296-0852
KSBHA_Licensing@ks.gov
www.ksbha.org
Laura Kelly, Governor

October 18, 2019

Final Notice

1423321
Steven Benjamin Bleyl, MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; Final Notice; 04-41987

Dear Dr. Steven Benjamin Bleyl:

This letter serves as your **final notice** for your audit. You were previously sent a letter on September 16, 2019.

The Kansas State Board of Healing Arts ("Board") is contacting you as part of the audit process. You have been selected to provide proof of your professional liability insurance and Kansas Health Care Stabilization Fund ("HCSF") compliance for your most recent renewal period (August 1, 2019 - July 31, 2020).

In Kansas, if you have an Active license, you are required to maintain professional liability insurance of not less than \$200,000 per claim, and not less than \$600,000 annual aggregate for all claims made during the policy period and required to maintain compliance with the HCSF (the HCSF provides supplemental professional liability coverage for health care providers affected by the Fund law). See K.S.A. 40-3402(a)-(b); K.S.A. 40-3404; K.S.A. 65-2809(c).

Please provide proof of your: (1) professional liability insurance; and (2) HCSF compliance for the period for which you renewed your license (August 1, 2019 - July 31, 2020), on or before November 1, 2019. Failure to produce this requested information may result in disciplinary action against your license, including but not limited to, a fine, a public censure, and/or **SUSPENSION** of your license. Submit all proof via email to KSBHA_Licensing@ks.gov.

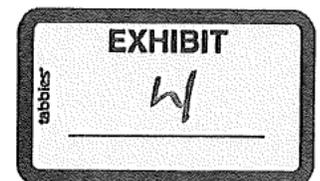
If you are unable to provide a Certificate of Compliance from HCSF, please contact HCSF through the contact information described below. Please remember, once you have obtained your Certificate of Compliance from HCSF, you must then submit a copy of the certification to the Board. Additionally, if you have questions regarding past expired coverage periods, please contact HCSF.

Kansas Health Care Stabilization Fund
300 SW 8th Ave, 2nd Floor
Topeka, KS 66603
Phone: (785) 291-3777
Fax: (785) 291-3550
Email: hcsf@ks.gov

Error! Hyperlink reference not valid. <https://hcsf.kansas.gov>

If you currently hold an Active license in Kansas, but do not actively practice in Kansas, you may want to consider changing your license status to either Exempt or Inactive. To change your license status, please submit an Application for Change of Designation/Type to the Board.

Kansas State Board of Healing Arts
Attn: MD Audit
800 SW Jackson, Lower Level – Suite A



Topeka, KS 66612
Phone: (785) 296-0934
Fax: (785) 296-0852
Email: KSBHA_Licensing@ks.gov

Sincerely,

Rebekah Moon

Licensing Administrator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level – Suite A
Topeka, Kansas 66612

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Garold O. Minns, MD
Bel Aire

TTY (Hearing Impaired) 711 or 1.800.766.3777 voice/TTY -- e-mail: KSBHA_healingarts@ks.gov

HCP Name	ID No.	Agency	License	Res.	Status	Retro Date	Address
BLEYL STEVEN	MD 119060	110	04-41987	N	A	11/20/2019	CONFIDENTIAL

Company	Policy	Rate Level	Fund Type	Effective	Expiration	Surcharge	Document reference numbers
CHUBB CUSTOM INSURANCE COMPANY	CONFIDENTIAL	1	C	11/20/2019	11/20/2020	\$ 100.00	

[Search Again](#) | [Return to HCSF Website](#)

Feedback

Our commitment to excellence involves receiving feedback from you. We would appreciate your feedback in the form of a brief survey describing your overall experience with this service.

