FILED

JUL 24 2020

KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	
Konstantin I. Denev, M.D.	)	
Kansas License No. 04-42016	)	**KSBHA Docket No. 20-HA00070**
	)	
	)	

Journal Entry of Satisfaction

The Kansas State Board of Healing Arts ("Board"), by its Acting Executive Director, Tucker L. Poling, a duly authorized representative of the Board, in accordance with the provisions of the Kansas Administrative Procedure Act, K.S.A. 77-501 *et seq.,* as amended, and upon due consideration of the agency record, the applicable statutes and regulations, and being otherwise duly advised in the premises, makes the following determinations:

1. On March 24, 2020, a Final Order was issued by the Board against the license of Konstantin I. Denev, M.D., ("Licensee"), imposing requirements therein.
2. Licensee has satisfactorily met all requirements of the Final Order and has no further obligations for compliance with the Final Order.

IT IS SO ORDERED.

Dated this 24th day of July 2020.

KANSAS STATE BOARD OF HEALING ARTS

Tucker L. Poling, Acting Executive Director
Kansas State Board of Healing Arts

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing **Journal Entry of Satisfaction** was served this 24th day of July 2020 by depositing the same in the United States Mail, first-class postage prepaid, and via email, addressed to:

Konstantin I. Denev, MD
CONFIDENTIAL

Licensee

And a copy hand delivered to:

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

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

And the original was filed with:

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

Jennifer Cook, Paralegal

EFFECTIVE AS A FINAL ORDER

DATE: 3/24/2020

FILED
MAR 04 2020
KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of **Konstantin I. Denev, M.D.** **Kansas License No. 04-42016**	**Docket No. 20-HA** 00070

SUMMARY ORDER

NOW ON THIS 4th day of March 2020, this matter comes before Tucker L. Poling, Interim Executive Director and General Counsel, 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. Konstantin I. Denev, M.D. ("Licensee") was issued License No. 04-42016 to practice medicine and surgery on May 1, 2019. Licensee's license status is currently 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:

a. On or about May 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 on September 24, 2018. (Exhibit 1.)

b. In a Letter of Qualification sent to Licensee on November 15, 2018, 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 KHCSF showed 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 8, 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 February 11, 2020, another search of the KHCSF showed Licensee was still not fund compliant and had never been. (Exhibit 5.)

g Licensee has been out of compliance with the KHCSF since on or about May 1, 2019 until at least February 11, 2020, while holding an Active license to practice medicine in Kansas.

h. To date, Licensee remains non-compliant with the fund.

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(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 Licensee is assessed a **CIVIL FINE** in the amount of **$500.00**, and also that his license is hereby **SUSPENDED** until such time as he comes into compliance with the KHCSF for violations of the Kansas Healing Arts Act. 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

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 4th **day of** March **2020.**

KANSAS STATE BOARD
OF HEALING ARTS

Tucker L. Poling
Interim Executive Director
General Counsel

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, Interim 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 24th day of March 2020 by depositing the same in the United States Mail, first-class, postage prepaid, and addressed to:

Konstantin I. Denev, MD
CONFIDENTIAL

Licensee

And a copy was hand-delivered to:

Meg Markey, Associate Litigation Counsel
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

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

Office of the General Counsel
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.

Jennifer Cook

Jennifer Cook, Paralegal

Bhakta, Chandni [BOHA]

From: Moon, Rebekah [BOHA]
Sent: Thursday, April 4, 2019 12:45 PM
To: Bhakta, Chandni [BOHA]
Subject: FW: Kansas Board

Thank you,

ATTENTION Doctors of Medicine and Surgery—If you are currently applying for your initial KS healing arts license, please note KS Board of Healing Arts requires all licensed professionals to renew their licenses annually.
Applicants licensed before May 1, 2019 will be required to renew in June of 2019, those licensed on May 1, 2019 or after will be required to renew in June of 2020. If you choose to be licensed after May 1, 2019 you will need to submit an email or letter stating the date you want to be licensed before your application has been completed. All Active licensees are required to have insurance and be in compliance with the Healthcare Stabilization Fund before you start practicing. Find out more at our website— http://www.ksbha.org/faq/faqlicensingrnwl.shtml

Rebekah Moon
Licensing Supervisor
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Phone 785.296.2562
Fax 785.296.0852
http://www.ksbha.org/main.shtml
Licensing Customer Satisfaction Survey

Confidentiality Notice: This message is from the Licensing Division of the Kansas State Board of Healing Arts and is intended only for the addressee. The information contained in this message is confidential, may be attorney-client privileged, may be privileged work product, may constitute protected health information not subject to disclosure under applicable federal or state laws, and is intended only for the use of the addressee. Unauthorized forwarding, printing, copying, distributing, or using such information is strictly prohibited and may be unlawful. If you are not the addressee, please promptly delete this message and notify the sender of the delivery error. E-mail is not a secure medium and there is no guarantee e-mail information will remain confidential. If you would prefer not to receive future communication by e-mail, please notify the sender.

The Kansas State Board of Healing Arts does not issue advisory opinions or render legal advice or services. Any and all statements herein should not be construed as legal advice relating to your particular situation or the establishment of an attorney-client relationship. Any information provided by Board staff is for general guidance and does not necessarily represent the opinions or position of the Board. The Kansas State Board of Healing Arts disclaims any and all responsibility and makes no warranties or representations whatsoever regarding the quality, content, completeness, or adequacy of the information provided on this matter. Board staff recommends you obtain independent legal counsel for an application of the law to your particular situation.

-----Original Message-----

CONFIDENTIAL

From: Konstantin Denev
Sent: Thursday, April 4, 2019 12:18 PM
To: Moon, Rebekah [BOHA] <Rebekah.Moon@ks.gov>
Cc: Alice Suarez (LT-ATL) <asuarez@locumtenens.com>
Subject: Kansas Board

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Hi Rebekah:

CONFIDENTIAL

Konstantin Denev, MD
CONFIDENTIAL

Bhakta, Chandni [BOHA]

From: Moon, Rebekah [BOHA]
Sent: Thursday, April 4, 2019 12:45 PM
To: Bhakta, Chandni [BOHA]
Subject: FW: Interstate Medical Licensure Compact Commission - Konstantin Ilkov Denev

Thank you,

ATTENTION Doctors of Medicine and Surgery—If you are currently applying for your initial KS healing arts license, please note KS Board of Healing Arts requires all licensed professionals to renew their licenses annually. **Applicants licensed before May 1, 2019 will be required to renew in June of 2019, those licensed on May 1, 2019 or after will be required to renew in June of 2020.** If you choose to be licensed after May 1, 2019 you will need to submit an email or letter stating the date you want to be licensed before your application has been completed. All Active licensees are required to have Insurance and be in compliance with the Healthcare Stabilization Fund before you start practicing.
Find out more at our website— http://www.ksbha.org/faq/faqlicensingrnwl.shtml

Rebekah Moon

Licensing Supervisor
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Phone 785.296.2562
Fax 785.296.0852
http://www.ksbha.org/main.shtml
Licensing Customer Satisfaction Survey

Confidentiality Notice: This message is from the Licensing Division of the Kansas State Board of Healing Arts and is intended only for the addressee. The information contained in this message is confidential, may be attorney-client privileged, may be privileged work product, may constitute protected health information not subject to disclosure under applicable federal or state laws, and is intended only for the use of the addressee. Unauthorized forwarding, printing, copying, distributing, or using such information is strictly prohibited and may be unlawful. If you are not the addressee, please promptly delete this message and notify the sender of the delivery error. E-mail is not a secure medium and there is no guarantee e-mail information will remain confidential. If you would prefer not to receive future communication by e-mail, please notify the sender.

The Kansas State Board of Healing Arts does not issue advisory opinions or render legal advice or services. Any and all statements herein should not be construed as legal advice relating to your particular situation or the establishment of an attorney-client relationship. Any information provided by Board staff is for general guidance and does not necessarily represent the opinions or position of the Board. The Kansas State Board of Healing Arts disclaims any and all responsibility and makes no warranties or representations whatsoever regarding the quality, content, completeness, or adequacy of the information provided on this matter. Board staff recommends you obtain independent legal counsel for an application of the law to your particular situation.

From: DocuSign NA3 System <dse_NA3@docusign.net>
Sent: Thursday, April 4, 2019 7:50 AM
To: KSBHA_InitialLicense <KSBHA_InitialLicense@ks.gov>
Subject: Interstate Medical Licensure Compact Commission - Konstantin Ilkov Denev

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

IMLC IStARS sent you a document to review and sign.

REVIEW DOCUMENTS

IMLC IStARS
IStARS@imlcc.net

Greetings! You have a new physician applying for a license from your Board. Please click "Review Documents" to download the physician's documentation and issue a license. When you have issued a license please click on the link above again and enter the license #, date of issuance, and expiration for the records.

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This message was sent to you by IMLC IStARS who is using the DocuSign Electronic Signature Service. If you would rather not receive email from this sender you may contact the sender with your request.

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR MEDICAL LICENSES IN IMLC MEMBER STATES

I, Konstantin Ilkov Denev (Type in full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for 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, that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect, that I hold a current and valid IMLC Letter of Qualification ("LOQ") issued on (Date) 11/15/2018 by (SPL) ILLINOIS as my State of Principal License, and that I continue to meet all requirements to qualify for the LOQ.

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 also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application, and further authorize the SPL and the Compact Commission ("Commission") 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, the Member Boards, 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 of 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, and revocation, or other disciplinary sanction, of my license(s) or permit(s) to practice medicine in one or more Compact Member States.

Physicians Signature DocuSigned by: Konstantin Ilkov Denev AAA1548BCABE44B...

Type Physician's Name Konstantin Ilkov Denev

Applicant's NPI 1437131299

DATE 3/29/2019 | 2:28 CDT

You will receive one or more emails regarding the status of your application(s) for license(s) from Member Board(s). If you have any concerns contact the Member Board(s) directly. Member Board contact information is on the www.IMLCC.org website. Be sure to check your spam folder and set your email to accept messages from the @docusign.net and @docusign.com domains.

Thank you for applying through the Interstate Medical Licensure Compact.

All fees are non-refundable

ch_1EJQMDJ1108IBBvt88xgblPE

DocuSign Envelope ID: 9F72C471-28A8-42A6-A927-8F4E7387DFA2

Letter of Qualification Verification

A review of records of the (Board) Illinois Division of Professional Regulation indicates that (Physician Name) Konstantin Ilkov Denev holds a Letter of Qualification for licensure in Member States of the Interstate Medical Licensure Compact. The Letter of Qualification was issued on (Issue Date) 11/15/2018 and will be valid for 365 days from that date.

(Board) IMLCC

In Process

DocuSigned by:
Marschall S. Smith
382E3B0AC253468...

Signature

Marschall S. Smith
Type Name

Executive Director
Title

4/3/2019 | 1:06 CDT
Date

PAYMENT FOR LICENSES

Below are the selected states in which you have indicated you wish to be licensed to practice medicine. Please sign as a payment agreement.

MEMBER BOARD(S)	COST OF LICENSE
IOWA BOARD OF MEDICINE	$450.00
KANSAS BOARD OF HEALING ARTS	$300.00

In Process

TOTAL $ 750

The selected state medical board(s) will be notified of your selection and issue the license(s).

Please note: All medical licenses issued 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.

Physician's Signature DocuSigned by: Konstantin Ilkov Denev D2F71CD5822648F...

Type Name Konstantin Ilkov Denev

DATE 4/4/2019 | 7:49 CDT

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

In Process

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 _____

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.

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

   ILLINOIS

2. Do you hold a full and unrestricted medical license to engage issued by a medical licensing board in the SPL (SPL Board) ILLINOIS DIVISION OF PROFESSIONAL REGULATION ? Yes x No

3. What is the license number issued to you by the SPL board? 036110062

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

IN PROCESS

   a. Your primary residence is in the SPL ILLINOIS : Yes x 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 ILLINOIS Yes x No

      If yes, describe your current practice Pediatric Emergency Medicine

      St. Alexius Medical Center

   c. Your employer is located in the SPL ILLINOIS : Yes x No

      If Yes, Employer name St. Alexius Medical Center

      Employer street address 1555 Barrington RD

      Employer City State Zip Hoffman Estates (City), IL (St), 60169 (Zip)

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

7. Have you successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association? Yes x 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 x 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 x

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 x

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 x

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

Physician's Signature: DocuSigned by: Konstantin Ilkov Denev AAA1548BCABE448...

Type Name: Konstantin Ilkov Denev, MD

Date: 9/24/2018 | 2:09 CDT

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

I, Konstantin Ilkov Denev, MD (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 ILLINOIS 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: Konstantin Ilkov Denev AAA1548BCABE44B...

Type Applicant's Name Konstantin Ilkov Denev

Applicant's NPI 1437131299

DATE 9/24/2018 | 2:09 CDT

In Process

PHYSICIAN'S CORE DATA SHEET

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

Full Legal Name Konstantin, Ilkov, Denev, ____
(Exactly as on DL or Passport) First Middle Last Suffix(Sr., Jr.)

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

CONFIDENTIAL

Mailing address ____ ____
Mailing address City State(XX) Zip

Office address 1555 Barrington Rd, Hoffman Estates, IL, 60169
Office address City State(XX) Zip

CONFIDENTIAL

Date of Birth ____ (mm/dd/yyyy) Gender: Male x Female

Physician's office or practice telephone number of public record 224-622-0776 (###-###-####)

In Process

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

Email address delegated by applicant to receive correspondence asuarez@locumtenens.com

CONFIDENTIAL

Social Security Number: ____ (###-##-####)

Physician's National Provider Identifier Number 1437131299

Medical Degree Received: M.D. x 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 Medicine Varna Faculty of Medicine
Name of School (no abbreviations or acronyms)

Date of Degree Issued 10/01/1996 (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 Mount Sinai School of Medicine Completion Date 07/01/2002
Full Program Name (no abbreviations or acronyms) (mm/dd/yyyy)

What is the specialty of the program Pediatrics

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

Number of attempts taken to pass the USMLE:

Step 1: 1 Step 2 CS: 1 Step 2 CK: 0 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 Pediatrics
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

Lifetime: In Process

Time limited: x Expiration date of time limited 02/15/2019
(mm/dd/yyyy)

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

License # 036110062 Date of Original Licensure 09/05/2003 (not renewal)
(mm/dd/yyyy)

Expiration Date 07/31/2020 Status of License: Current: x 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: Tim W. Marley 77F5D9C1A54E403...

Type Name Tim W. Marley

Title IDPR Supervisor

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

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
email Address	asuarez@locumtenens.com	konstantin_bg@yahoo.com
Date of Degee Issued	10/01/1996	10/08/1996
Residency Completion Date	07/01/2002	06/30/2002
Illinois License #	036110062	036.110062
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A

In Process

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Konstantin Ilkov Denev
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 1437131299

Medical Board Name Montana Board of Medical Examiners

Member Board License Number MED-PHYS-LIC-70113

Date License Issued 11/19/2018
mm/dd/yyyy

Date of Expiration 03/31/2020
mm/dd/yyyy

In Process

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

Member Board Signature DocuSigned by: Ian Marquand E07F13864B74BE...

Type Name Ian Marquand

DATE 11/19/2018 | 3:17 CST

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Konstantin Ilkov DENEV
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 1437131299

Medical Board Name Nevada State Board of Medical Examiners

Member Board License Number 18457

Date License Issued 11/21/2018
mm/dd/yyyy

Date of Expiration 06/30/2019
mm/dd/yyyy

In Process

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

Member Board Signature DocuSigned by: L Daniels D548998D99EA496...

Type Name Lynnette Daniels, Chief of Licensing

DATE 11/26/2018 | 2:46 CST

Letter of Qualification

Date 11/15/2018
mm/dd/yyyy

Name: Konstantin Ilkov Denev
CONFIDENTIAL

Address:

CityStZip

Dear Dr. Denev:

RE: Your application for IMLC Letter of Qualification

The ILLINDIS DIVISION OF PROFESSIONAL REGULATION ("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 DocuSigned by: Tim W. Marley 77F5D9C1A54E403...

Type Name Tim W. Marley

Title of Authorized SPL IDPR Supervisor

DATE 11/15/2018 | 2:37 CST

PAYMENT FOR LICENSES

Below are the selected states in which you have indicated you wish to be licensed to practice medicine. Please sign as a payment agreement.

MEMBER BOARD(S)	COST OF LICENSE
IDAHO BOARD OF MEDICINE	$397.00
MONTANA BOARD OF MEDICAL EXAMINERS	$500.00
NEVADA STATE BOARD OF MEDICAL EXAMINERS	$375.00

In Process

TOTAL $ 1272

The selected state medical board(s) will be notified of your selection and issue the license(s).

Please note: All medical licenses issued 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.

Physician's Signature DocuSigned by: Konstantin Ilkov Denev D2F71CD5822948F...

Type Name Konstantin Denev, MD

DATE 11/16/2018 | 1:25 CST

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Konstantin Ilkov Denev
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 1437131299

Medical Board Name Idaho State Board of Medicine

Member Board License Number MC-0142

Date License Issued 11/20/2018
mm/dd/yyyy

Date of Expiration 06/30/2020
mm/dd/yyyy

In Process

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

Member Board Signature DocuSigned by: Mary Johnson FF9624C4FA09454...

Type Name Mary Johnson

DATE 11/20/2018 | 8:05 PST

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 2/1/2019

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 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
DENISE D. BARNES
USI HEALTHCARE – A DIVISION OF USI SOUTHWEST, INC.
9811 KATY FREEWAY, SUITE 500
HOUSTON, TX 77024

CONTACT NAME: MARLENE EDWARDS
PHONE (A/C, No, Ext): 713-490-4685 FAX (A/C, No): 713-343-5025
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: NATIONAL FIRE & MARINE INSURANCE COMPANY	20079
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
LOCUMTENENS.COM, LLC
2655 NORTHWINDS PARKWAY, STE. 300
ALPHARETTA, GA 30009

COVERAGES **CERTIFICATE NUMBER:** **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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YY)	POLICY EXP (MM/DD/YY)	LIMITS	
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS-MADE OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC			N/A	N/A	N/A	EACH OCCURRENCE	$ N/A
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ N/A
							MED EXP (Any one person)	$ N/A
							PERSONAL & ADV INJURY	$ N/A
							GENERAL AGGREGATE	$ N/A
							PRODUCTS – COMP/OP AGG	$ N/A
							EMPLOYEE BENEFITS	$ N/A
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			N/A	N/A	N/A	COMBINED SINGLE LIMIT (Ea accident)	$ N/A
							BODILY INJURY (Per person)	$ N/A
							BODILY INJURY (Per accident)	$ N/A
							PROPERTY DAMAGE (Per accident)	$ N/A
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS MADE DED RETENTION $			N/A	N/A	N/A	EACH OCCURRENCE	$ N/A
							AGGREGATE	$ N/A
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under Y / N DESCRIPTION OF OPERATIONS below	N / A		N/A	N/A	N/A	WC STATU-TORY LIMITS OTH-ER	
							E.L. EACH ACCIDENT	$ N/A
							E.L. DISEASE – EA EMPLOYEE	$ N/A
							E.L. DISEASE – POLICY LIMIT	$ N/A
A	MEDICAL PROFESSIONAL LIABILITY – CLAIMS MADE			HN006655	07/01/18	07/01/19	$1,000,000 EACH MEDICAL INCIDENT $3,000,000 PER PROVIDER ANNUAL AGGREGATE $15,000,000 TOTAL POLICY AGGREGATE	

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
LIMITS INCLUDE ALL SELF-INSURED RETENTION AMOUNTS
COVERED PERSON: **KONSTANTIN DENEV, MD (342298)**, ONLY WHILE WORKING FOR OR ON BEHALF OF THE NAMED INSURED.

*For Credentialing, please send this COI, your request and signed release to Western Litigation Email: Credentialing@WesternLitigation.com Phone: 713-935-2454

CERTIFICATE HOLDER

UCHEALTH MEMORIAL HOSPITAL CENTRAL
1400 EAST BOULDER STREET
COLORADO SPRINGS, CO 80909

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

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

Kansas
State Board of Healing Arts

PHONE: 785-296-7413
FAX: 785-368-7103
KSBHA_healingarts@ks.gov
www.ksbha.org

Kathleen Selzler-Lippert, Executive Director

Laura Kelly, Governor

April 15, 2019

Konstantin Ilkov Denev, MD
CONFIDENTIAL

Dear Konstantin Ilkov Denev:

This letter is to inform you that your application for a Medical Doctor (MD) Pending license in the State of Kansas was approved by the Board of Healing Arts. Your original wall certificate will be mailed in 2 to 4 weeks and you will receive all wallet cards via the email provided to the Board.

This is to serve as evidence that you have been assigned Kansas License Number 04-42016 effective: 05/01/2019. This license is valid until the next renewal period.

The renewal period for Medical Doctor (MD) is 1 year. Prior to cancellation on 07/31/2020, a renewal notice will be mailed to your current email and mailing address listed with our office. It is critical that our office has your current contact information. It is **your** duty to ensure our office has your current contact information.

If you have moved since you completed an application with us, it is imperative that you submit that information via writing. Your address **cannot** be changed until we receive this notification: Address Change Request Form.

If you have any questions, please feel free to contact the Board Office at KSBHA_InitialLicense@ks.gov.

Sincerely,

Kathleen Selzler Lippert

Kathleen Selzler Lippert
Executive Director

BOARD MEMBERS: ROBIN D. DURRETT, DO, PRESIDENT, Great Bend • STEVEN J. GOULD, DC, VICE PRESIDENT, Cheney • MARK BALDERSTON, DC, Shawnee
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GAROLD O. MINNS, MD, Bel Aire • JOHN F. SETTICH, PH.D., PUBLIC MEMBER, Atchison • KIMBERLY J. TEMPLETON, MD, Leawood • RONALD M. VARNER, DO, Augusta

Bhakta, Chandni [BOHA]

From: Moon, Rebekah [BOHA]
Sent: Thursday, April 11, 2019 2:39 PM
To: Bhakta, Chandni [BOHA]
Subject: FW: Completed: Interstate Medical Licensure Compact Commission - Konstantin Ilkov Denev
Attachments: Affidavit and Consent Second Use Case 8.2017.docx.pdf; LOQ Verification Second Use Case.docx.pdf; Payment for Licenses 8.2017.docx.pdf; IMLCC_Application - Dr. Denev 3-29-2019.pdf; Medical License Issuance Information 8.2017.docx.pdf

Thank you,

ATTENTION Doctors of Medicine and Surgery—If you are currently applying for your initial KS healing arts license, please note KS Board of Healing Arts requires all licensed professionals to renew their licenses annually. **Applicants licensed before May 1, 2019 will be required to renew in June of 2019, those licensed on May 1, 2019 or after will be required to renew in June of 2020.** If you choose to be licensed after May 1, 2019 you will need to submit an email or letter stating the date you want to be licensed before your application has been completed. All Active licensees are required to have Insurance and be in compliance with the Healthcare Stabilization Fund before you start practicing.
Find out more at our website— http://www.ksbha.org/faq/faqlicensingrnwl.shtml

Rebekah Moon

Licensing Supervisor
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Phone 785.296.2562
Fax 785.296.0852
http://www.ksbha.org/main.shtml
Licensing Customer Satisfaction Survey

Kansas Confidentiality Notice: This message is from the Licensing Division of the Kansas State Board of Healing Arts and is intended only for the addressee. The information contained in this message is confidential, may be attorney-client privileged, may be privileged work product, may constitute protected health information not subject to disclosure under applicable federal or state laws, and is intended only for the use of the addressee. Unauthorized forwarding, printing, copying, distributing, or using such information is strictly prohibited and may be unlawful. If you are not the addressee, please promptly delete this message and notify the sender of the delivery error. E-mail is not a secure medium and there is no guarantee e-mail information will remain confidential. If you would prefer not to receive future communication by e-mail, please notify the sender.

The Kansas State Board of Healing Arts does not issue advisory opinions or render legal advice or services. Any and all statements herein should not be construed as legal advice relating to your particular situation or the establishment of an attorney-client relationship. Any information provided by Board staff is for general guidance and does not necessarily represent the opinions or position of the Board. The Kansas State Board of Healing Arts disclaims any and all responsibility and makes no warranties or representations whatsoever regarding the quality, content, completeness, or adequacy of the information provided on this matter. Board staff recommends you obtain independent legal counsel for an application of the law to your particular situation.

From: DocuSign NA3 System <dse_NA3@docusign.net>
Sent: Thursday, April 11, 2019 2:37 PM

To: KSBHA_InitialLicense <KSBHA_InitialLicense@ks.gov>
Subject: Completed: Interstate Medical Licensure Compact Commission - Konstantin Ilkov Denev

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Your document has been completed

VIEW COMPLETED DOCUMENTS

IMLC IStARS
IStARS@imlcc.net

All parties have completed Interstate Medical Licensure Compact Commission - Konstantin Ilkov Denev.

Greetings! You have a new physician applying for a license from your Board. Please click "Review Documents" to download the physician's documentation and issue a license. When you have issued a license please click on the link above again and enter the license #, date of issuance, and expiration for the records.

Powered by

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Visit DocuSign.com, click 'Access Documents', and enter the security code:
FB8B22BCF9F84C28AEF67F20FBB38FDD3

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If you are having trouble signing the document, please visit the Help with Signing page on our Support Center.

Download the DocuSign App

This message was sent to you by IMLC ISIARS who is using the DocuSign Electronic Signature Service. If you would rather not receive email from this sender you may contact the sender with your request.

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR MEDICAL LICENSES IN IMLC MEMBER STATES

I, Konstantin Ilkov Denev (Type in full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for 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, that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect, that I hold a current and valid IMLC Letter of Qualification ("LOQ") issued on (Date) 11/15/2018 by (SPL) ILLINOIS as my State of Principal License, and that I continue to meet all requirements to qualify for the LOQ.

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 also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application, and further authorize the SPL and the Compact Commission ("Commission") 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, the Member Boards, 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 of 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, and revocation, or other disciplinary sanction, of my license(s) or permit(s) to practice medicine in one or more Compact Member States.

Physicians Signature DocuSigned by: Konstantin Ilkov Denev AAA1548BCABE44B...

Type Physician's Name Konstantin Ilkov Denev

Applicant's NPI 1437131299

DATE 3/29/2019 | 2:28 CDT

You will receive one or more emails regarding the status of your application(s) for license(s) from Member Board(s). If you have any concerns contact the Member Board(s) directly. Member Board contact information is on the www.IMLCC.org website. Be sure to check your spam folder and set your email to accept messages from the @docusign.net and @docusign.com domains.

Thank you for applying through the Interstate Medical Licensure Compact.

All fees are non-refundable

ch_1EJQMDJ11o8IBBVt88xgblPE

DocuSign Envelope ID: 9F72C471-28A8-42A6-A927-8F4E7387DFA2

Letter of Qualification Verification

A review of records of the (Board) Illinois Division of Professional Regulation indicates that (Physician Name) Konstantin Ilkov Denev holds a Letter of Qualification for licensure in Member States of the Interstate Medical Licensure Compact. The Letter of Qualification was issued on (Issue Date) 11/15/2018 and will be valid for 365 days from that date.

(Board) IMLCC

DocuSigned by:
Marschall S. Smith
382E3[illegible]
Signature

Marschall S. Smith
Type Name

Executive Director
Title

4/3/2019 | 1:06 CDT
Date

PAYMENT FOR LICENSES

Below are the selected states in which you have indicated you wish to be licensed to practice medicine. Please sign as a payment agreement.

MEMBER BOARD(S)	COST OF LICENSE
IOWA BOARD OF MEDICINE	$450.00
KANSAS BOARD OF HEALING ARTS	$300.00

TOTAL $ 750

The selected state medical board(s) will be notified of your selection and issue the license(s).

Please note: All medical licenses issued 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.

Physician's Signature DocuSigned by: Konstantin Ilkov Denev D2F71CD5822946F...

Type Name Konstantin Ilkov Denev

DATE 4/4/2019 | 7:49 CDT

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Konstantin Ilkov Denev
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 1437131299

Medical Board Name Kansas Board of Healing Arts

Member Board License Number 04-42016

Date License Issued 5/1/2019
mm/dd/yyyy

Date of Expiration 07/31/2020
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 DocuSigned by: KANSAS BOARD OF HEALING ARTS 1D2E5882D48C422...

Type Name Rebekah Moon

DATE 4/11/2019 | 2:36 CDT

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.

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

   ILLINOIS

2. Do you hold a full and unrestricted medical license to engage issued by a medical licensing board in the SPL (SPL Board) ILLINOIS DIVISION OF PROFESSIONAL REGULATION ? Yes x No

3. What is the license number issued to you by the SPL board? 036110062

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

   a. Your primary residence is in the SPL ILLINOIS : Yes X No

      If yes, provide the following:

      Residence Street addres CONFIDENTIAL

      Residence City State Zip
      City St Zip

   b. At least 25% of your practice of medicine occurs in the SPL ILLINOIS Yes x No

      If yes, describe your current practice Pediatric Emergency Medicine

      St. Alexius Medical Center

   c. Your employer is located in the SPL ILLINOIS : Yes x No

      If Yes, Employer name St. Alexius Medical Center

      Employer street address 1555 Barrington RD

      Employer City State Zip Hoffman Estates IL , 60169
      City St Zip

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

7. Have you successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association? Yes x 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 x 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 x

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 x

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 x

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

Physician's Signature: DocuSigned by: Konstantin Ilkov Denev AAA1548BCABE44B...

Type Name: Konstantin Ilkov Denev, MD

Date: 9/24/2018 | 2:09 CDT

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

I, Konstantin Ilkov Denev, MD (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 ILLINOIS 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: Konstantin Ilkov Denev AAA154BBCABE44B...

Type Applicant's Name Konstantin Ilkov Denev

Applicant's NPI 1437131299

DATE 9/24/2018 | 2:09 CDT

PHYSICIAN'S CORE DATA SHEET

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

Full Legal Name Konstantin, Ilkov, Denev, _____
(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 1555 Barrington Rd, Hoffman Estates IL, 60169
Office address City State(XX) Zip

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

Physician's office or practice telephone number of public record 224-622-0776 (###-###-####)

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

Email address delegated by applicant to receive correspondence asuarez@locumtenens.com

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

Physician's National Provider Identifier Number 1437131299

Medical Degree Received: M.D. x 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 Medicine Varna Faculty of Medicine
Name of School (no abbreviations or acronyms)

Date of Degree Issued 10/01/1996 (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 Mount Sinai School of Medicine Completion Date 07/01/2002
Full Program Name (no abbreviations or acronyms) (mm/dd/yyyy)

What is the specialty of the program Pediatrics

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

Number of attempts taken to pass the USMLE:

Step 1: 1 Step 2 CS: 1 Step 2 CK: 0 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 Pediatrics
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

Lifetime:

Time limited: x Expiration date of time limited 02/15/2019
(mm/dd/yyyy)

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

License # 036110062 Date of Original Licensure 09/05/2003 (not renewal)
(mm/dd/yyyy)

Expiration Date 07/31/2020 Status of License: Current: x 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: Tim W. Marley 77F5D8C1A54E403...

Type Name Tim W. Marley

Title IDPR Supervisor

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

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
email Address	asuarez@locumtenens.com	konstantin_bg@yahoo.com
Date of Degee Issued	10/01/1996	10/08/1996
Residency Completion Date	07/01/2002	06/30/2002
Illinois License #	036110062	036.110062
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Konstantin Ilkov Denev
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 1437131299

Medical Board Name Montana Board of Medical Examiners

Member Board License Number MED-PHYS-LIC-70113

Date License Issued 11/19/2018
mm/dd/yyyy

Date of Expiration 03/31/2020
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 DocuSigned by: Ian Marquand E87F13864B874BE...

Type Name Ian Marquand

DATE 11/19/2018 | 3:17 CST

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Konstantin Ilkov DENEV
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 1437131299

Medical Board Name Nevada State Board of Medical Examiners

Member Board License Number 18457

Date License Issued 11/21/2018
mm/dd/yyyy

Date of Expiration 06/30/2019
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 DocuSigned by: L Daniels D548996D99EA498...

Type Name Lynnette Daniels, Chief of Licensing

DATE 11/26/2018 | 2:46 CST

Letter of Qualification

Date 11/15/2018
mm/dd/yyyy

Name: Konstantin Ilkov Denev

CONFIDENTIAL

Address:

CityStZip

Dear Dr. Denev:

RE: Your application for IMLC Letter of Qualification

The ILLINOIS DIVISION OF PROFESSIONAL REGULATION ("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 DocuSigned by: Tim W. Marley 77E5D9C1A54E403...

Type Name Tim W. Marley

Title of Authorized SPL IDPR Supervisor

DATE 11/15/2018 | 2:37 CST

PAYMENT FOR LICENSES

Below are the selected states in which you have indicated you wish to be licensed to practice medicine. Please sign as a payment agreement.

MEMBER BOARD(S)	COST OF LICENSE
IDAHO BOARD OF MEDICINE	$397.00
MONTANA BOARD OF MEDICAL EXAMINERS	$500.00
NEVADA STATE BOARD OF MEDICAL EXAMINERS	$375.00

TOTAL $ 1272

The selected state medical board(s) will be notified of your selection and issue the license(s).

Please note: All medical licenses issued 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.

Physician's Signature DocuSigned by: Konstantin Ilkov Denev 02F71CD5822946F...

Type Name Konstantin Denev, MD

DATE 11/16/2018 | 1:25 CST

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Konstantin Ilkov Denev
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 1437131299

Medical Board Name Idaho State Board of Medicine

Member Board License Number MC-0142

Date License Issued 11/20/2018
mm/dd/yyyy

Date of Expiration 06/30/2020
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 DocuSigned by: Mary Johnson FF9624C4FA09454...

Type Name Mary Johnson

DATE 11/20/2018 | 8:05 PST

Bhakta, Chandni [BOHA]

From: Moon, Rebekah [BDHA]
Sent: Thursday, April 4, 2019 12:45 PM
To: Bhakta, Chandni [BDHA]
Subject: FW: Konstantin Ilkov Denev, MD

Thank you,

ATTENTION Doctors of Medicine and Surgery— If you are currently applying for your initial KS healing arts license, please note KS Board of Healing Arts requires all licensed professionals to renew their licenses annually. **Applicants licensed before May 1, 2019 will be required to renew in June of 2019, those licensed on May 1, 2019 or after will be required to renew in June of 2020.** If you choose to be licensed after May 1, 2019 you will need to submit an email or letter stating the date you want to be licensed before your application has been completed. All Active licensees are required to have Insurance and be in compliance with the Healthcare Stabilization Fund before you start practicing.
Find out more at our website— http://www.ksbha.org/faq/faqlicensingrnwl.shtml

Rebekah Moon

Licensing Supervisor
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Phone 785.296.2562
Fax 785.296.0852
http://www.ksbha.org/main.shtml
Licensing Customer Satisfaction Survey

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From: Alice Suarez (LT-ATL) <asuarez@locumtenens.com>
Sent: Thursday, April 4, 2019 8:31 AM
To: Moon, Rebekah [BOHA] <Rebekah.Moon@ks.gov>
Subject: RE: Konstantin Ilkov Denev, MD

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Thanks so much!

Alice Suarez
Licensing Specialist
Hospital Medicine

email: asuarez@locumtenens.com
phone: 678-690-7760

fax: 404-751-5158
call toll free 800-562-6663
Provide feedback on my service

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From: Moon, Rebekah [BOHA] <Rebekah.Moon@ks.gov>
Sent: Thursday, April 4, 2019 9:30 AM
To: Alice Suarez (LT-ATL) <asuarez@locumtenens.com>
Subject: RE: Konstantin Ilkov Denev, MD

Hello Alice,

We just received the request today. The request to go active May 1st will need to come directly from the physician and it can be emailed directly to me and I will wait to send the compact application to an analyst until the request is received, so that it can be processed together. If you have any other questions please feel free to email me.

Thank you,

ATTENTION Doctors of Medicine and Surgery— If you are currently applying for your initial KS healing arts license, please note KS Board of Healing Arts requires all licensed professionals to renew their licenses annually.
Applicants licensed before May 1, 2019 will be required to renew in June of 2019, those licensed on May 1, 2019 or after will be required to renew in June of 2020. If you choose to be licensed after May 1, 2019 you will need to submit an email or letter stating the date you want to be licensed before your application has been completed. All Active licensees are required to have insurance and be in compliance with the Healthcare Stabilization Fund before you start practicing.
Find out more at our website— http://www.ksbha.org/faq/faqlicensingrnwl.shtml

Rebekah Moon

Licensing Supervisor
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612

Phone 785.296.2562
Fax 785.296.0852
http://www.ksbha.org/main.shtml
Licensing Customer Satisfaction Survey

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From: Alice Suarez (LT-ATL) <asuarez@locumtenens.com>
Sent: Thursday, April 4, 2019 8:11 AM
To: Moon, Rebekah [BOHA] <Rebekah.Moon@ks.gov>
Subject: RE: Konstantin Ilkov Denev, MD

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Rebekah,

I would like to delay the issuance of Dr. Denev's license until after May 1st. Can I do that for him or does he have to send the request? What email should it be sent to? I know the Compact licenses issue fairly quickly so I want to get this to you as soon as possible.

The fee was paid this morning so you should be getting the compact request this morning.

Thank you,

Alice Suarez
Licensing Specialist
Hospital Medicine

email: asuarez@locumtenens.com
phone: 678-690-7760

fax: 404-751-5158
call toll free 800-562-8663
Provide feedback on my service

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From: Moon, Rebekah [BOHA] <Rebekah.Moon@ks.gov>
Sent: Wednesday, April 3, 2019 5:49 PM
To: Alice Suarez (LT-ATL) <asuarez@locumtenens.com>
Subject: RE: Konstantin Ilkov Denev, MD

Hello Alice,

I'm not showing the Kansas State Board received a request from the IMLC for the named applicant. You will need to contact the IMLC to follow up on the request.

Thank you,

ATTENTION Doctors of Medicine and Surgery—If you are currently applying for your initial KS healing arts license, please note KS Board of Healing Arts requires all licensed professionals to renew their licenses annually. **Applicants licensed before May 1, 2019 will be required to renew in June of 2019, those licensed on May 1, 2019 or after will be required to renew in June of 2020.** If you choose to be licensed after May 1, 2019 you will need to submit an email or letter stating the date you want to be licensed before your application has been completed. All Active licensees are required to have Insurance and be in compliance with the Healthcare Stabilization Fund before you start practicing.
Find out more at our website— http://www.ksbha.org/faq/faqlicensingrnwl.shtml

Rebekah Moon

Licensing Supervisor
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Phone 785.296.2562
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Licensing Customer Satisfaction Survey

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From: Alice Suarez (LT-ATL) <asuarez@locumtenens.com>
Sent: Wednesday, April 3, 2019 4:07 PM
To: KSBHA_InitialLicense <KSBHA_InitialLicense@ks.gov>
Subject: FW: Konstantin Ilkov Denev, MD

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Good afternoon! On 3/29 a request was submitted for a subsequent license in the state of KS; however, I do not believe there was an opportunity to pay the license fee for Kansas. Can you confirm that you've received the Compact licensure request for Konstantin Ilkov Denev, MD? I want to make sure the fee is paid and the license is processed.

Thank you for your assistance,

Alice Suarez
Licensing Specialist
Hospital Medicine

email: asuarez@locumtenens.com
phone: 678-690-7760

fax: 404-751-5158
call toll free 800-562-8663
Provide feedback on my service

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Letter of Qualification

Date 11/15/2018
mm/dd/yyyy

Name: Konstantin Ilkov Denev

CONFIDENTIAL

Address:

CityStZip

Dear Dr. Denev:

RE: Your application for IMLC Letter of Qualification

The ILLINOIS DIVISION OF PROFESSIONAL REGULATION ("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 DocuSigned by: Tim W. Marley 77E5D9C1A54E403...

Type Name Tim W. Marley

Title of Authorized SPL IDPR Supervisor

DATE 11/15/2018 | 2:37 CST

EXHIBIT
tabbies
2

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

State Board of Healing Arts

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

1426427
Konstantin Ilkov Denev MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; 04-42016

Dear Dr. Denev:

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).

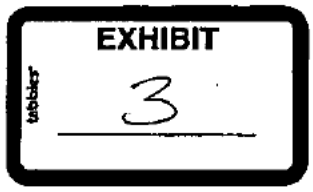
According to the Board's records, you most recently renewed your license for the period of August 1, 2019, through July 31, 2010. On that renewal, you agreed to maintain and produce proof of professional liability insurance and KHCSF compliance upon request. *See generally* K.S.A. 65-2809(c).

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



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

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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

1426427
Konstantin Ilkov Denev, MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; Final Notice; 04-42016

Dear Dr. Konstantin Ilkov Denev:

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(e).

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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Workman, Hester [BOHA]

From: Anderson, Lorie [HCSF]
Sent: Tuesday, February 11, 2020 4:29 PM
To: Workman, Hester [BOHA]
Cc: Markey, Meg [BOHA]
Subject: RE: Compliance verification update
Attachments: HCSF compliance history (3).pdf

Hester,

Thank you for submitting each providers license number. That is very helpful. I have attached the compliance histories of those providers we show a compliance record for. There are eleven we have no compliance history.

1. [redacted] No compliance record
2. [redacted]
3. [redacted]
4. [redacted]
5. Konstantin I. Denev,M.D. 04-42016 No compliance record
6. [redacted] No compliance record
7. [redacted] No compliance record
8. [redacted] No compliance record
9. [redacted]
10. [redacted]
11. [redacted]
12. [redacted] No compliance record
13. G[redacted]
14. J[redacted] No compliance record
15. N[redacted]
16. F[redacted]
17. B[redacted]
18. J[redacted] No compliance record

EXHIBIT
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5

19. [redacted] No compliance record

20. [redacted]

21. [redacted]

22. [redacted]

23. [redacted] No compliance record

24. [redacted]

25. [redacted] No compliance record

26. [redacted]

27. [redacted]

28. [redacted]

29. [redacted]

30. [redacted]

31. [redacted]

32. [redacted]

Thank you,
Lorie

Lorie Anderson
Director of Compliance
Kansas Health Care Stabilization Fund
300 SW 8th Avenue, 2nd Flr
Topeka, Kansas 66603-3912
785.291.3475
785.291.3550 Fax
Lorie.Anderson@ks.gov

[redacted]