FILED
SEP 21 2020
KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	
Robert P. Lynch, M.D.	)	
Kansas License No. 04-40814	)	**KSBHA Docket No. 21-HA00005**
	)	
	)	

Journal Entry of Satisfaction

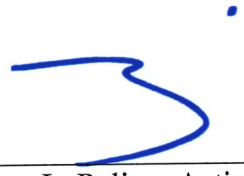
The Kansas State Board of Healing Arts ("Board"), by its Acting Executive Director, Tucker L. Poling, a duly authorized representative of the Board, in accordance with the provisions of the Kansas Administrative Procedure Act, K.S.A. 77-501 *et seq.,* as amended, and upon due consideration of the agency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

1. On September 15, 2020, a Final Order was issued by the Board against the license of Robert P. Lynch, 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 21st day of September 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 28th day of September 2020 by depositing the same in the United States Mail, first-class postage prepaid, and via email, addressed to:

Robert P. Lynch, M.D.
CONFIDENTIAL

Licensee

And a copy hand delivered to:

J. Todd Hiatt
Litigation Counsel
Matthew Gaus
Associate Litigation Counsel
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612

Compliance Coordinator
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

Ali B for
Jennifer Cook, Paralegal

EFFECTIVE AS A FINAL ORDER

DATE: 9.15.20

FILED

AUG 27 2020

KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of **Robert P. Lynch, M.D.** **Kansas License No. 04-40814**	**Docket No. 21-HA00005**

AMENDED SUMMARY ORDER

NOW ON THIS 27th day of August 2020, this matter comes before Tucker L. Poling, Acting Executive Director, Kansas State Board of Healing Arts ("Board"), in summary proceedings pursuant to K.S.A. 77-537.

Pursuant to K.S.A 77-537 and K.S.A. 77-542, this Amended 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. Robert P. Lynch, M.D. ("Licensee") was issued License No. 04-40814 to practice medicine and surgery on May 1, 2018. On or about August 25, 2020, Licensee changed his license status to Inactive.

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 March 30, 2018, Licensee applied for an Active license by and through an Application For Medical Licenses In IMLC Member States. Licensee's application stated that "I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses I hold." Licensee signed and acknowledged this statement. (Exhibit 1.)

b. In a Letter of Qualification sent to Licensee, Licensee was told, "You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions." (emphasis in original). Licensee received this notice in his Letter of Qualification. (Exhibit 2.)

c. After he had been granted an Active license, a search of the KHCSF showed Licensee was not in compliance with the Kansas Healthcare Stabilization Fund ("KHCSF") beginning February 2, 2019.

d. On September 16, 2019, and October 18, 2019, the Board requested Licensee to provide proof of compliance with the 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 July 21, 2020, another search of the KHCSF showed Licensee was still not fund compliant. (Exhibit 5.)

g. Licensee was previously out of compliance with the KHCSF since on or about February 2, 2019, while holding an Active license to practice medicine and surgery in Kansas.

h. On or about August 25, 2020, Licensee submitted an Application for Change of Designation/Type to the Board requesting that his license status be changed to Inactive status, making him now compliant with the KHCSF. (Exhibit 6.)

Applicable Law

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

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

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

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

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

> (1) Every insurance company authorized to transact business in this state, that is authorized to issue professional liability insurance in any jurisdiction, shall file with the commissioner, as a condition of its continued transaction of business within this state, a form prescribed by the commissioner declaring that its professional liability insurance policies, wherever issued, shall be deemed to provide at least the insurance required by this subsection when the insured is rendering professional services as a nonresident health care provider in this state. Any nonadmitted insurer may file such a form.
>
> (2) Every nonresident health care provider who is required to maintain basic coverage pursuant to this subsection shall pay the surcharge levied by the board of governors pursuant to subsection (a) of K.S.A. 40-3404 and amendments thereto directly to the board of governors and shall furnish to the board of governors the information required in subsection (a)(1). . .

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

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

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

payable to the board of governors. In the case of a nonresident health care provider or a self-insurer, the premium surcharge shall be paid upon submitting documentation of compliance with K.S.A. 40-3402, and amendments thereto.

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

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

Conclusions of Law

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

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

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

IT IS HEREBY ORDERED that Licensee's license is hereby **PUBLICLY CENSURED,** and that Licensee is assessed a **CIVIL FINE** in the amount of one-thousand dollars (**$1,000.00**) for violations of the Kansas Healing Arts Act, due within thirty (30) days after this Order becomes a Final Order. Such fine shall be paid to the "Kansas State Board of Healing Arts," in full. All

monetary payments, which shall be in the form of check or money order, relating to this Amended 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 27th **day of** August **2020.**

KANSAS STATE BOARD OF HEALING ARTS

Tucker L. Poling
Acting Executive Director

FINAL ORDER NOTICE OF RIGHTS

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

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that a true copy of the foregoing **FINAL ORDER** was served this 15th day of September 2020 by depositing the same in the United States Mail, first-class, postage prepaid, and addressed to:

Robert P. Lynch, M.D.
CONFIDENTIAL

Licensee

And a copy was hand-delivered to:

J. Todd Hiatt,
Litigation Counsel
Matthew Gaus
Associate Litigation Counsel
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612

Compliance Coordinator
Kansas State Board of Healing A11s
800 SW Jackson, Lower Level - Suite A
Topeka, Kansas 66612

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

Staff signature

QUALIFICATIONS APPLICATION

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

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

   WASHINGTON M.D.

2. Do you hold a full and unrestricted medical license to engage issued by a medical licensing board in the SPL (SPL Board) WASHINGTON MEDICAL COMMISSION ? Yes x No

3. What is the license number issued to you by the SPL board? MD 00029406

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

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

      If yes, provide the following:

      Residence Street addre CONFIDENTIAL

      Residence City State Zip _____ City, _____ St _____ Zip

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

      If yes, describe your current practice General Surgery, clinic and Call

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

      If Yes, Employer name Self employed

      Employer street address CONFIDENTIAL

      Employer City State Zip _____ City, _____ St, _____ Zip

   d. You have designated the SPL WASHINGTON M.D. 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)

EXHIBIT

tabbies

1

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

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

DocuSigned by:

Physician's Signature: Robert Paul Lynch

889068CD01D2408...

Type Name: Robert Paul Lynch, MD

Date: 2/5/2018 | 12:00 CST

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

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

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

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

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

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

Applicant Signature DocuSigned by: Robert Paul Lynch 889068CD01D2408...

Type Applicant's Name Robert Paul Lynch, MD

Applicant's NPI 1336219476

DATE 2/5/2018 | 12:00 CST

In Process

PHYSICIAN'S CORE DATA SHEET

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

Full Legal Name Robert (First), Paul (Middle), Lynch (Last), _____ (Suffix(Sr., Jr.))

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

CONFIDENTIAL

Mailing addre

Office addres _____ (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 253-631-8962 (###-###-####)

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

Physician's Email Address to receive correspondence CONFIDENTIAL

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

Physician's National Provider Identifier Number 1336219476

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 Ohio State University College of Medicine (Name of School (no abbreviations or acronyms))

Date of Degree Issued 06/11/1982 (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 Good Samaritan Hospital, Cincinnati, Ohio (Full Program Name (no abbreviations or acronyms)) Completion Date 06/30/1987 (mm/dd/yyyy)

What is the specialty of the program General Surgery

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

Number of attempts taken to pass the USMLE:

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

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: 1 Step 2: 1 Step 3: 1

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

Specialty Board Certification: American Board of Surgery
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 12/31/2022
(mm/dd/yyyy)

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

License # MD 00029406 Date of Original Licensure 02/12/1992 (not renewal)
(mm/dd/yyyy)

Expiration Date 06/29/2019 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: Kimberly M. Romero A9E71BFB17A84C1...

Type Name Kimberly M. Romero

Title Licensing Manager

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

DocuSign Envelope ID: C784C9C6-09CD-4A90-BCBE-05A4F53D7193

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
EXAM	FLEX	NBME CERT# 272548

In Process

Letter of Qualification

Date 03/27/2018
mm/dd/yyyy

Name: Robert Paul Lynch

CONFIDENTIAL

Address

CityStZip

Dear Dr. Lynch:

RE: Your application for IMLC Letter of Qualification

The WASHINGTON MEDICAL COMMISSION ("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.

DocuSigned by:
Authorized Signature from SPL Kimberly M. Romero
A9E71BFB17A61C...

Type Name Kimberly M. Romero

Title of Authorized SPL Licensing Manager

DATE 3/27/2018 | 11:47 CDT

DocuSign Envelope ID: C784C9C6-09CD-4A90-BCBE-05A4F53D7193

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
KANSAS BOARD OF HEALING ARTS	$300.00

To Pay

TOTAL $ 300

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: Robert Paul Lynch B053CB8DEC9D47B...

Type Name Robert P. Lynch, MD, FACS

DATE 3/30/2018 | 3:47 CDT

DocuSign Envelope ID: C784C9C6-09CD-4A90-BCBE-05A4F53D7193

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 _____

Stormont Vail Health

FAX

TO:
Name: **KSBHA Lic Waiver-Beth**
Company:
Fax#: 3687102
Transition Date: 4/12/2018 2:07:26 PM

FROM:
Office: Credentialing – Medical Staff Services
Main Phone: (785) 354-6241
Fax#: (785) 354-6734
Number of pages including This Page: 2

PLEASE NOTE: The information contained on this fax transmittal form and in any accompanying documents are legally privileged and confidential communications intended only for the use of the designated recipient(s) named above. If the reader of this message is not the intended recipient(s), you are hereby notified that you have received the document in error and that any use, review, dissemination, distribution, disclosure, or copying of this message is strictly prohibited. If you have received this communication in error, please notify us immediately by the telephone number listed above and destroy the documents received. Thank you.

Medical Staff Office Personnel
Credentialing Team
Direct Contact Information:

Karen S. Reed-Coffman, MBA, CPMSM, CPCS
Director, Medical Staff Services
Ph. 785-354-6245
kreedco@stormontvail.org

Paul Root, CPCS
Credentialing Supervisor
Ph. 785-354-6242
paroot@stormontvail.org

Jane Murray
Credentialing Specialist
Ph. 785-354-6229
jamurra@stormontvail.org

Tracey Konrade
Credentialing Specialist
Ph. 785-354-6337
tkonrade@stormontvail.org

Tammy Lewis
Credentialing Coordinator
Ph. 785-354-5201
talewis@stormontvail.org

Kynthia Nelson
Medical Staff Services Coordinator
Ph. 785-354-6264
kynelso@stormontvail.org

SVHAppCentralCred@stormontvail.org

Hello Beth,
thank you for speaking with me in regards to the Kansas lic waiver for Dr. Robert Lynch. I appreciate your time and help in this process.
Tracey

Your timely response is greatly appreciated!
Thank You

Kansas

AUTHORIZATION AND RELEASE INFORMATION

Please complete if you would like for Board staff to talk with others concerning your application.

I, Robert Lynch, MD (print name), hereby authorize the Kansas State Board of Healing Arts ("Board") to release and discuss any and all information pertaining to my application pending before the Board with the following individual(s):

Name of Individual / Phone number	Relationship to Individual
Tracey Konrade/ 785-354-6337	Stormont Vail Credentialing Specialist
Paul Root/ 785-354-6242	Stormont Vail Credentialing Supervisor
Karen Reed-Coffman/ 785-354-6245	Stormont Vail Medical Staff Director

I understand that this Authorization and Release may be revoked only in writing. A reproduction of this Authorization and Release shall have the same effect as the original.

Signature

6 April 2018

Date

Massey, Theresa [BOHA]

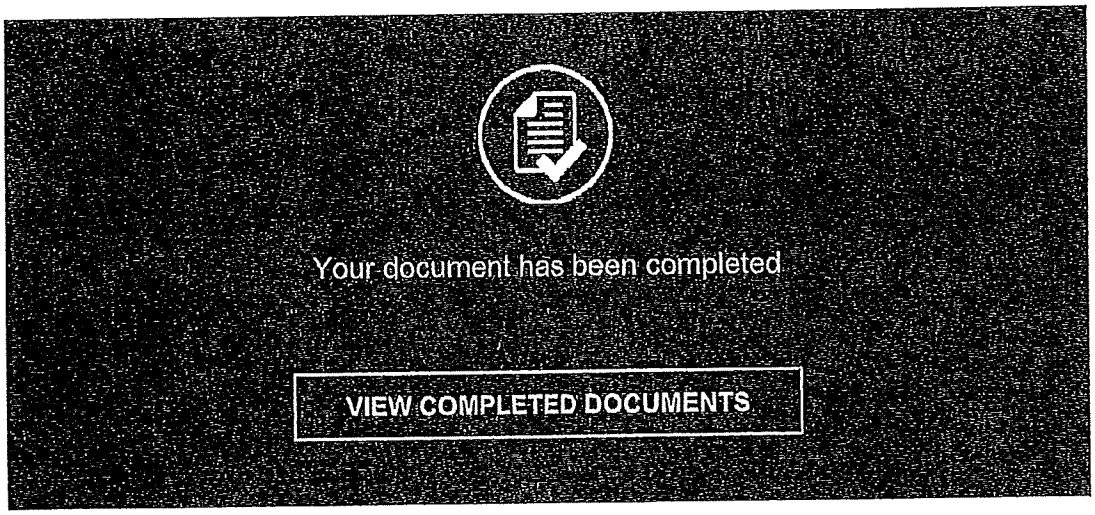
From: Schlesener, Nichole [BOHA]
Sent: Wednesday, April 25, 2018 1:47 PM
To: Massey, Theresa [BOHA]
Subject: FW: Completed: Interstate Medical Licensure Compact Commission - Robert Paul Lynch
Attachments: Qualifications Application v.3.docx.pdf; Affidavit and Consent 8.2017.docx.pdf; Core Data Sheet v. 3.docx.pdf; Correction Sheet.docx.pdf; Letter of Qualification 8.2017.docx.pdf; Payment for Licenses 8.2017.docx.pdf; Medical License Issuance Information 8.2017.docx.pdf

Thanks,

Nichole Schlesener

Licensing Administrator

From: DocuSign NA3 System [mailto:dse_NA3@docusign.net]
Sent: Wednesday, April 25, 2018 1:46 PM
To: KSBHA_Doctors <KSBHA_Doctors@ks.gov>
Subject: Completed: Interstate Medical Licensure Compact Commission - Robert Paul Lynch



IMLC IStARS
IStARS@imlcc.net

All parties have completed Interstate Medical Licensure Compact Commission - Robert Paul Lynch.

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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About DocuSign
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Questions about the Document?
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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.

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)?:

   WASHINGTON M.D.

2. Do you hold a full and unrestricted medical license to engage issued by a medical licensing board in the SPL (SPL Board) WASHINGTON MEDICAL COMMISSION ? Yes x No

3. What is the license number issued to you by the SPL board? MD 00029406

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

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

      If yes, describe your current practice General Surgery,

      clinic and Call

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

      If Yes, Employer name Self employed

      Employer street addres: CONFIDENTIAL

      Employer City State Zip _____ City St Zip _____

   d. You have designated the SPL WASHINGTON M.D. 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

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

DocuSigned by:

Physician's Signature: Robert Paul Lynch

889868CD01D2408...

Type Name: Robert Paul Lynch, MD

Date: 2/5/2018 | 12:00 CST

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

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

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

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

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

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

Applicant Signature DocuSigned by: Robert Paul Lynch 889668CD01D2409...

Type Applicant's Name Robert Paul Lynch, MD

Applicant's NPI 1336219476

DATE 2/5/2018 | 12:00 CST

PHYSICIAN'S CORE DATA SHEET

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

Full Legal Name Robert (First), Paul (Middle), Lynch (Last), _____ (Suffix(Sr., Jr.))

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

CONFIDENTIAL

Mailing addres

Office address

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 253-631-8962 (###-###-####)

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

Physician's Email Address to receive correspondence CONFIDENTIAL

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

Physician's National Provider Identifier Number 1336219476

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 Ohio State University College of Medicine (Name of School (no abbreviations or acronyms))

Date of Degree Issued 06/11/1982 (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 Good Samaritan Hospital, Cincinnati, Ohio (Full Program Name (no abbreviations or acronyms)) Completion Date 06/30/1987 (mm/dd/yyyy)

What is the specialty of the program General Surgery

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

Number of attempts taken to pass the USMLE:

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

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: 1 Step 2: 1 Step 3: 1

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

Specialty Board Certification: American Board of Surgery
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 12/31/2022
(mm/dd/yyyy)

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

License # MD 00029406 Date of Original Licensure 02/12/1992 (not renewal)
(mm/dd/yyyy)

Expiration Date 06/29/2019 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: Kimberly M. Romero A9E71BFB17A04C1...

Type Name Kimberly M. Romero

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

Title Licensing Manager

DocuSign Envelope ID: C784C9C6-09CD-4A90-BCBE-05A4F53D7193

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
EXAM	FLEX	NBME CERT# 272548

Letter of Qualification

Date 03/27/2018
mm/dd/yyyy

Name: Robert Paul Lynch

CONFIDENTIAL

Address:

CityStZip

Dear Dr. Lynch:

RE: Your application for IMLC Letter of Qualification

The WASHINGTON MEDICAL COMMISSION ("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: Kimberly M. Romero A0E71BFB17A04C1...

Type Name Kimberly M. Romero

Title of Authorized SPL Licensing Manager

DATE 3/27/2018 | 11:47 CDT

DocuSign Envelope ID: C784C9C6-09CD-4A90-BCBE-05A4F53D7193

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
KANSAS BOARD OF HEALING ARTS	$300.00

TOTAL $ 300

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: Robert Paul Lynch B053CB8DEC9D47B...

Type Name Robert P. Lynch, MD, FACS

DATE 3/30/2018 | 3:47 CDT

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Robert (First Name) Paul (Middle Name) Lynch (Last Name)

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

National Provider Identifier Number 1336219476

Medical Board Name Kansas State Board of Healing Arts

Member Board License Number 04-40814

Date License Issued 05/01/2018
mm/dd/yyyy

Date of Expiration 07/31/2019
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: Nichole M. Schlesener 307A212DA6974FD...

Type Name Nichole M. Schlesener

DATE 4/25/2018 | 1:45 CDT

Massey, Theresa [BOHA]

From: Massey, Theresa [BOHA]
Sent: Tuesday, April 3, 2018 8:49 AM
To: Schlesener, Nichole [BOHA]
Subject: Compact application Robert Lynch
Attachments: EnvelopePDF.pdf

Hello Nichole,

I have a couple of questions for you regarding Dr. Lynch's application. Please see the attachment.

1. He put his SPL as Washington M.D. and on Primary Residence - Is that ok?
2. His residence address and his practice address are the same. – Is that ok? – He does state he is self-employed.

Thanks,

Theresa Massey
Licensing Analyst
Healing Arts Professions
Kansas State Board of Healing Arts
800 SW Jackson LL Ste A
Topeka, KS 66612
☎: 785 296-0934
🖷: 785 296-0852
✉: theresa.massey@ks.gov
🖱: www.ksbha.org

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.

Letter of Qualification

Date 03/27/2018
mm/dd/yyyy

Name: Robert Paul Lynch

CONFIDENTIAL

Address:

CityStZip

Dear Dr. Lynch:

RE: Your application for IMLC Letter of Qualification

The WASHINGTON MEDICAL COMMISSION ("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: Kimberly M. Romero A0E71BFB17A84C...

Type Name Kimberly M. Romero

Title of Authorized SPL Licensing Manager

DATE 3/27/2018 | 11:47 CDT

EXHIBIT 2

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

Kathleen Selzler Lippert, Executive Director

phone: 785-296-7413
fax: 785-296-0852
Email: KSBHA_healingarts@ks.gov
www.ksbha.org

Laura Kelly, Governor

September 16, 2019

SEP 25 2019

Applicant ID # 1422735
Robert Lynch, MD
CONFIDENTIAL

blynchmd@outlook.com

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; License # 04-40814

Dear Dr. Lynch:

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.

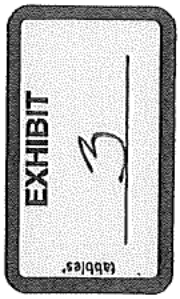
In Kansas, if you have an Active license, you are required to maintain professional liability insurance of not less than $200,000 per claim, and not less than $600,000 annual aggregate for all claims made during the policy period. *See* K.S.A. 40-3402(a)-(b); K.S.A. 65-2809(c). Additionally, you are 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, 2020. 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.

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



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:

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

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

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

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

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

Sincerely,

Rebekah Moon

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

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

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

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

October 18, 2019

Final Notice

1422735
Robert Paul Lynch, MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; Final Notice; 04-40814

Dear Dr. Robert Paul Lynch:

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

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

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

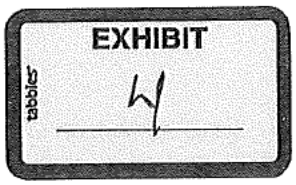
Please provide proof of your: (1) professional liability insurance; and (2) HCSF compliance for the period for which you renewed your license (August 1, 2019 - July 31, 2020), on or before **November 1, 2019**. Failure to produce this requested information may result in disciplinary action against your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

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

Kansas Health Care Stabilization Fund
300 SW 8th Ave, 2nd Floor
Topeka, KS 66603
Phone: (785) 291-3777
Fax: (785) 291-3550
Email: hcsf@ks.gov
Error! Hyperlink reference not valid.https://hcsf.kansas.gov

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

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



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

Sincerely,

Rebekah Moon

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

Board Members:
Steven J. Gould, DC, President
Cheney
R. Jerry DeGrado, DC
Wichita
Anne Hodgdon, Public Member
Lenexa
David Laha, DPM
Overland Park
Kimberly J. Templeton, MD
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Robin D. Durrett, DO
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Joel R. Hutchins, MD
Holton
Douglas J. Milfeld, MD
Wichita
Ronald M. Varner, DO
Augusta
Mark Balderston, DC
Shawnee
Tom Estep, MD
Wichita
Steve Kelly, Public Member
Newton
Gerold O. Minns, MD
Bel Aire

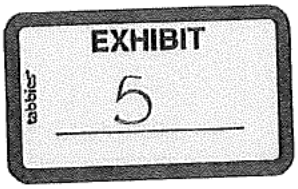
HCP Name		ID No.	Agency	License	Res.	Status	Retro Date	Address
LYNCH ROBERT	MD	114192	110	04-40814	N	A	05/15/2018	CONFIDENTIAL

Company	Policy	Rate Level	Fund Type	Effective	Expiration	Surcharge	Document reference numbers
CONTINENTAL CASUALTY CO	CONFIDENTIAL 7	2108 8	C	05/15/2018	02/01/2019	$ 139.00	

Search Again | Return to HCSF Website

Feedback

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



RECEIVED
By KSBHA at 11:46 am, Aug 25, 2020

Kansas

APPLICATION FOR CHANGE OF DESIGNATION/TYPE

Please enter required information, sign and date on the bottom of page 2.
E-mail form with required documentation and credit card form to
KSBHA_Licensing@ks.gov

License No. 04 - 40814 ☒ Medicine & Surgery ☐ Chiropractic ☐ Osteopathic ☐ Podiatry

Current Type: ☒ Active ☐ Federal Active ☐ Military ☐ Exempt ☐ Inactive

Name: Robert (First) Paul (Middle) Lynch (Last)

Home Address: CONFIDENTIAL
Street City State Zip

Home Telephone Number: CONFIDENTIAL E-Mail Address: CONFIDENTIAL

Business Address: Same
Street City State Zip

Business Telephone Number: E-Mail Address:

Preferred Mailing Address: ☒ Home ☐ Business

EFFECTIVE 25 / 08 / 2020 The effective date **CANNOT be a retroactive date** and must be a date in the future from the date the Board receives your request.

I request a license type change to:(check the license type below)

Please select only **ONE** type.

☐ **Active:** A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

1. List in chronological order all professional activities since your license was last Active or initially issued if the license was never Active (use additional pages if necessary):

From:MO/YR To:MO/YR	Complete Address	Position Held

2. If rendering any professional services in Kansas, you are required by law to maintain professional liability insurance of not less than $200,000 per claim, $600,000 annual aggregate, and participate in the Kansas Health Care Stabilization Fund (KHCSF). You must provide proof that your professional liability insurance is in compliance. Proof of insurance may be a notice of coverage, certificate of insurance or notification of insurance binder from your agent. Non-residents must submit a copy of their non-resident certificate form. If you have any questions about participation with KHCSF call please (785) 291-3777.

3. If your continuing education is not current, proof of your continuing education hours must be included with your application. You may verify your continuing education year by reviewing your wallet card or visiting our website www.ksbha.org,

4. Since the last renewal date of your Kansas license, have you:

☐ Yes ☐ No had an adverse judgment, award, or settlement resulting from a professional liability claim?
☐ Yes ☐ No had a disciplinary action taken or initiated against you by a state licensing agency or surrendered or consented to limitation of your license to practice in any state?
☐ Yes ☐ No had any hospital privileges suspended?
☐ Yes ☐ No been found guilty or pled no contest to a felony or Class A misdemeanor?

Attach documentation and an explanation if your answer is "yes" to any of the above questions.

EXHIBIT
tabbies
6

☐ **Federal Active:** A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practices that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration, and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

1. Location of Federal Employment: _____
Name of Employer Street City State Zip

2. If your continuing education is not current, proof of your continuing education hours must be included with your application. You may verify your continuing education year by reviewing your wallet card or visiting our website www.ksbha.org.

3. List in chronological order all professional activities since your license was last Active or initially issued if the license was never Active (use additional pages if necessary):

From:MO/YR To:MO/YR	Complete Address	Position Held

4. Since the last renewal date of your Kansas license, have you:

☐ Yes ☐ No had an adverse judgment, award, or settlement resulting from a professional liability claim?
☐ Yes ☐ No had a disciplinary action taken or initiated against you by a state licensing agency or surrendered or consented to limitation of your license to practice in any state?
☐ Yes ☐ No had any hospital privileges suspended?
☐ Yes ☐ No been found guilty or pled no contest to a felony or Class A misdemeanor?

Attach documentation and an explanation if your answer is "yes" to any of the above questions.

☐ **Exempt:** A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

I intend to engage in the following professional activities in Kansas:

☐ Consultant
☐ Treatment of Family and Friends with No Compensation
☐ Other: _____
☐ Charitable Health Care Provider
☐ Coroner/Deputy Coroner
☐ Administration
☐ None

☐ **I acknowledge by marking the check box, with an exempt license I will not be a health care provider as defined by K.S.A. 40-3401, that I am not required to maintain professional liability insurance in accordance with K.S.A. 40-3401 and that services I render while a holder of an exempt license will not be insured or covered by the Health Care Stabilization Fund.**

☒ **Inactive:** A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

Fees: Please complete the credit card authorization form or make your check payable to Kansas State Board of Healing Arts.

Current Type of	
	Active or Federal Active changing to any type: No Fee
	Military changing to Active or Federal Active: $330
	Military changing to Exempt or Inactive: $150
	Exempt or Inactive changing to Exempt or Inactive: No Fee
	Exempt or Inactive changing to Active or Federal Active: $175

I certify under penalty of perjury under the laws of the State of Kansas that the information provided on this form, including supporting documentation is true and correct and that I am licensed to practice in the State of Kansas.

Signature _____ Date 26 Aug 2020

revised 3/6/19

From:	Robert Lynch
To:	KSBHA_Licensing
Subject:	Kansas board of Healing Arts; RE: inactivation of MD license
Date:	Tuesday, August 25, 2020 9:51:41 AM
Attachments:	KSBHA25 aug 2020Scan.pdf

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.

Dear Sirs:

Please see attached form to immediately inactivate my MD license in Kansas,

Thank you for your time,

R. Lynch, MD, FACS