FILED

APR 22 2020

KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	
Anne Scholl Moore, M.D.	)	**KSBHA Docket No. 20-HA00072**
Kansas License No. 04-41515	)	
	)	

JOURNAL ENTRY OF SATISFACTION

The Kansas State Board of Healing Arts ("Board"), by its Interim 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 31, 2020, a Final Order was issued by the Board against the license of Anne Scholl Moore, 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 22nd day of April 2020.

KANSAS STATE BOARD OF HEALING ARTS

Tucker L. Poling
Interim Executive Director

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the above and foregoing **Journal Entry of Satisfaction**, by depositing the same in the United States mail, first class postage prepaid and emailed, on this 22nd day of April 2020, addressed to:

CONFIDENTIAL

Licensee

And a copy hand delivered to:

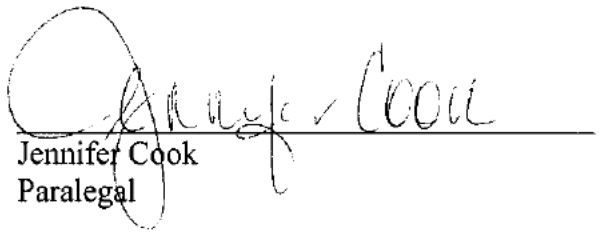
Compliance Coordinator
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

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

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

and the original was filed with:

Tucker Poling, Interim 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: 3/31/2020

FILED

MAR 11 2020

KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS OF THE STATE OF KANSAS

In the Matter of **Anne Scholl Moore, M.D.** **Kansas License No. 04-41515**	**Docket No. 20-HA00072**

AMENDED SUMMARY ORDER

NOW ON THIS 11th 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. Anne Scholl Moore, M.D. ("Licensee") was issued License No. 04-41515 to practice medicine and surgery on October 3, 2018. On or about March 5, 2020, Licensee changed her 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 October 3, 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 her Letter of Qualification. (Exhibit 2.)

c. After she 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 July 1, 2019 and up to and until November 8, 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 February 11, 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 July 1, 2019 until at least February 11, 2020, while holding an Active license to practice medicine and surgery in Kansas.

h. On or about February 25, 2020, Licensee submitted an Application for Change of Designation/Type to the Board requesting that her license status be changed to Inactive status. On or about March 5, 2020, Licensee's license status was changed to Inactive, making her 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(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** for violations of the Kansas Healing Arts Act, due within thirty (30) days after this Order becomes a Final Order. Such fine shall be paid to the "Kansas State Board of Healing Arts," in full. All monetary payments, which shall be in the form of check or money order, relating to this Summary Order shall be mailed to the Board certified and addressed to:

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

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 11th **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 31st day of March 2020 by depositing the same in the United States Mail, first-class, postage prepaid, and addressed to:

Anne Scholl Moore, 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: Wednesday, October 3, 2018 11:34 AM
To: Bhakta, Chandni [BOHA]
Subject: FW: Interstate Medical Licensure Compact Commission - Anne Scholl Moore

Hey girl hey!!! Could you please get this one entered and sent to final review today or tomorrow. I told the credentialing advisor I would get it approved ASAP.

Thank you!!

ATTENTION Chiropractic Doctors—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 November 1, 2018 will be required to renew in January of 2019, those licensed on November 1, 2018 or after will be required to renew in January of 2020. If you choose to be licensed after November 1, 2018 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

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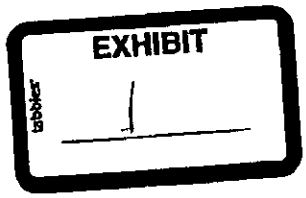
The Kansas State Board of Healing Arts does not issue advisory opinions or render legal advice or services. Any and all statements herein should not be construed as legal advice relating to your particular situation or the establishment of an attorney-client relationship. Any information provided by 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: Massey, Theresa [BOHA]
Sent: Wednesday, October 3, 2018 11:24 AM
To: Moon, Rebekah [BOHA] <Rebekah.Moon@ks.gov>
Subject: FW: Interstate Medical Licensure Compact Commission - Anne Scholl Moore

This is the one you were waiting on.

Thank you,



Theresa Massey

Licensing Analyst
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

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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: Wednesday, October 3, 2018 10:47 AM
To: KSBHA_Doctors <KSBHA_Doctors@ks.gov>
Subject: Interstate Medical Licensure Compact Commission - Anne Scholl Moore

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.

Error! Filename not specified.

IMLC IStARS sent you a document to review and sign.

REVIEW DOCUMENTS

IMLC IStARS
IStARS@imlcc.net

PRIVATE MESSAGE
Greetings! You have a new Physician qualified to practice on your Board. Please click the "Review Documents" to download the physicians documentation and issue a license. When you have issued a license please click on the link above again and enter in the license #, date of issuance, and expiration for the records.

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.

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)?:

   COLORADO

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

3. What is the license number issued to you by the SPL board? 21074

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

IN PROCESS

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

      If yes, describe your current practice ED/Urgent Care for Children's Hospital colorado

      ED and urgent care

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

      If Yes, Employer name Children's Hospital Colorado

      Employer street address 13123 East 16th Ace

      Employer City State Zip Aurora (City), CO (St), 80045 (Zip)

   d. You have designated the SPL COLORADO 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: DOCA684F6C5C424...

Type Name: Anne Schott Moore

Date: 8/14/2018 | 9:18 CDT

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

I, Anne S Moore (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 COLORADO 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: D0CA864F8C5C424...

Type Applicant's Name Anne S Moore

Applicant's NPI 1649481391

DATE 8/14/2018 | 9:18 CDT

In Process

PHYSICIAN'S CORE DATA SHEET

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

Full Legal Name Anne, Scholl, Moore, _____
(Exactly as on DL or Passport) First Middle Last Suffix(Sr., Jr.)

Other names used(maiden, birth) Anne Patrick Scholl
First Middle Last

CONFIDENTIAL

Mailing addres
Mailing address City State(XX) Zip

Office address 13123 East 16th ave, Aurora, CO, 80045
Office address City State(XX) Zip

CONFIDENTIAL

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

Physician's office or practice telephone number of public record 303-724-6635
(###-###-####)

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

Email address delegated by applicant to receive correspondence ___ CONFIDENTIAL

CONFIDENTIAL

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

Physician's National Provider Identifier Number 1649481391

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 Rochester SchoolIf Medicine
Name of School (no abbreviations or acronyms)

Date of Degree Issued 05/25/1974
(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 North Carolina Memorial Hospital Completion Date 06/30/1977
Full Program Name (no abbreviations or acronyms) (mm/dd/yyyy)

What is the specialty of the program Pediatrics

Qualifying Licensing exam taken: USMLE COMLEX Other X National Board of Medical exami
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: Pediatrics
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

Lifetime: X

In Process

Time limited: Expiration date of time limited_____
(mm/dd/yyyy)

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

License # 21074 Date of Original Licensure 06/25/1977 (not renewal)
(mm/dd/yyyy)

Expiration Date 04/30/2019 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: COLORADO MEDICAL BOARD 720A52A25130400...

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

Type Name Shannon Davidson

Title Licensing Specialist

DocuSign Envelope ID: 3E23DE76-0596-416C-8564-6E3C3781ECA6

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

In Process

DocuSign Envelope ID: 3E23DE76-0596-416C-8564-6E3C3781ECA6

Letter of Qualification

Date 09/27/2018
mm/dd/yyyy

Name: Anne Scholl Moore
CONFIDENTIAL

Address:

CityStZip

Dear Dr. Moore :

RE: Your application for IMLC Letter of Qualification

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

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

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

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

Authorized Signature from SPL DocuSigned by: COLORADO MEDICAL BOARD
720A52A251304CC...

Type Name Shannon Davidson

Title of Authorized SPL Licensing Specialis

DATE 9/27/2018 | 12:02 CDT

DocuSign Envelope ID: 3E23DE76-0596-416C-8564-6E3C3781ECA6

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

In Process

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 JMLC 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: Anne Scholl Moore A7824AFAA55E455...

Type Name Anne Scholl Moore

DATE 10/3/2018 | 10:47 CDT

DocuSign Envelope ID: 3E23DE76-0596-416C-8564-6E3C3781ECA6

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 _____

STATE OF KANSAS

KANSAS STATE BOARD OF HEALING ARTS
800 SW JACKSON, LOWER LEVEL-SUITE A
TOPEKA, KS 66612

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

GOVERNOR JEFF COLYER M.D.
KATHLEEN SELZLER-LIPPERT, EXECUTIVE DIRECTOR

October 3, 2018

Anne Scholl Moore. MD
CONFIDENTIAL

Dear Anne Scholl Moore:

This letter is to inform you that your application for a Medical Doctor (MD) Active 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 04-41515 effective: 10/03/2018. This license is valid until the next renewal period.

The renewal period for Medical Doctor (MD) is 1 year. Prior to cancellation on 07/31/2019, 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, Chaney • R. JERRY DEGRADO, DC, Wichita
TOM EATEP, MD, Wichita • ANNE HODGDON, PUBLIC MEMBER, Lenexa • JOEL R. HUTCHINS, MD, Holton • DAVID LAHA, DPM, Overland Park
M. MYRON LEINWETTER, DO, Rossville • DOUGLAS J. MILFELD, MD, Wichita • GAROLD O. MINNIS, 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: Wednesday, October 3, 2018 12:54 PM
To: Bhakta, Chandni [BOHA]
Subject: FW: Completed: Interstate Medical Licensure Compact Commission - Anne Scholl Moore
Attachments: Qualifications Application v.4.docx.pdf; Affidavit and Consent 8.2017.docx.pdf; Core Data Sheet v. 4.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

Thank you,

ATTENTION Chiropractic Doctors— 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 November 1, 2018 will be required to renew in January of 2019, those licensed on November 1, 2018 or after will be required to renew in January of 2020. If you choose to be licensed after November 1, 2018 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

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: Massey, Theresa [BOHA]
Sent: Wednesday, October 3, 2018 12:53 PM
To: Moon, Rebekah [BOHA] <Rebekah.Moon@ks.gov>
Subject: FW: Completed: Interstate Medical Licensure Compact Commission - Anne Scholl Moore

Thank you,

Theresa Massey

Licensing Analyst
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.

From: DocuSign NA3 System <dse_NA3@docusign.net>
Sent: Wednesday, October 3, 2018 12:49 PM
To: KSBHA_Doctors <KSBHA_Doctors@ks.gov>
Subject: Completed: Interstate Medical Licensure Compact Commission - Anne Scholl Moore

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.

Error! Filename not specified.

Your document has been completed

VIEW COMPLETED DOCUMENTS

IMLC IStARS
IStARS@imlcc.net

All parties have completed Interstate Medical Licensure Compact Commission - Anne Scholl Moore.

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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Visit DocuSign.com, click 'Access Documents', and enter the security code:
8D122778AF5E4F7F8356A58BD3A6EED63

About DocuSign
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Questions about the Document?
If you need to modify the document or have questions about the details in the document, please reach out

to the sender by emailing them directly.

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 ISrARS 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)?:

   COLORADO

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

3. What is the license number issued to you by the SPL board? 21074

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

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

      If yes, provide the following:

      CONFIDENTIAL

      Residence Street addres:

      Residence City State Zip , City St Zip

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

      If yes, describe your current practice ED/Urgent Care for Children's Hospital colorado

      ED and urgent care

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

      If Yes, Employer name Children's Hospital Colorado

      Employer street address 13123 East 16th Ace

      Employer City State Zip Aurora , CO , 80045
      City St Zip

   d. You have designated the SPL COLORADO 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: DOCA884F8C5C424...

Type Name: Annie Schott Moore

Date: 8/14/2018 | 9:18 CDT

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

I, Anne S Moore (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 COLORADO 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: D0CA884F8C5C424...

Type Applicant's Name Anne S Moore

Applicant's NPI 1649481391

DATE 8/14/2018 | 9:18 CDT

PHYSICIAN'S CORE DATA SHEET

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

Full Legal Name Anne, Scholl, Moore, ____
(Exactly as on DL or Passport) First Middle Last Suffix(Sr., Jr.)

Other names used(maiden, birth) Anne Patrick Scholl
First Middle Last

CONFIDENTIAL

Mailing address

Office address 13123 East 16th ave, Aurora, CO, 80045
Office address City State(XX) Zip

CONFIDENTIAL

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

Physician's office or practice telephone number of public record 303-724-6635
(###-###-####)

CONFIDENTIAL

Physician's cellular or alternative telephone numbe ____
(###-###-####)

Email address delegated by applicant to receive correspondence CONFIDENTIAL

CONFIDENTIAL

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

Physician's National Provider Identifier Number 1649481391

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 Rochester SchoolIf Medicine
Name of School (no abbreviations or acronyms)

Date of Degree Issued 05/25/1974
(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 North Carolina Memorial Hospital Completion Date 06/30/1977
Full Program Name (no abbreviations or acronyms) (mm/dd/yyyy)

What is the specialty of the program Pediatrics

Qualifying Licensing exam taken: USMLE COMLEX Other x National Board of Medical exami
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: Pediatrics
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

Lifetime: x

Time limited: Expiration date of time limited_____
(mm/dd/yyyy)

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

License # 21074 Date of Original Licensure 06/25/1977 (not renewal)
(mm/dd/yyyy)

Expiration Date 04/30/2019 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: COLORADO MEDICAL BOARD
729A52A25130466...

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

Type Name Shannon Davidson

Title Licensing Specialist

DocuSign Envelope ID: 3E23DE76-0596-416C-6564-6E3C3781ECA6

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

Letter of Qualification

Date 09/27/2018
mm/dd/yyyy

Name: Anne Scholl Moore

CONFIDENTIAL

Address:

CityStZip

Dear Dr. Moore:

RE: Your application for IMLC Letter of Qualification

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Authorized Signature from SPL DocuSigned by: COLORADO MEDICAL BOARD 720A52A251304CC...

Type Name Shannon Davidson

Title of Authorized SPL Licensing Specialis

DATE 9/27/2018 | 12:02 CDT

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

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Physician's Signature DocuSigned by: Anne Scholl Moore A7624AFAA55E455...

Type Name Anne Scholl Moore

DATE 10/3/2018 | 10:47 CDT

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Anne Scholl Moore
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 169481391

Medical Board Name Kansas Board of Healing Arts

Member Board License Number 04-41515

Date License Issued 10/03/2018
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: KANSAS BOARD OF HEALING ARTS 307A212DA6974FD...

Type Name Rebekah Moon

DATE 10/3/2018 | 12:49 CDT

Letter of Qualification

Date 09/27/2018
mm/dd/yyyy

Name: Anne Scholl Moore
CONFIDENTIAL

Address: ____

____

CityStZip ____

Dear Dr. Moore:

RE: Your application for IMLC Letter of Qualification

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Authorized Signature from SPL DocuSigned by: COLORADO MEDICAL BOARD
728A52A25190400...

Type Name Shannon Davidson

Title of Authorized SPL Licensing Specialis

DATE 9/27/2018 | 12:02 CDT

EXHIBIT
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

1424904
Anne Scholl Moore, MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; 04-41515

Dear Dr. Moore:

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

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

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

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

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

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

Sincerely,

Rebekah Moon

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

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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

1424904
Anne Scholl Moore, MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; Final Notice; 04-41515

Dear Dr. Anne Scholl Moore:

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

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

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

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

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

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

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

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

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

Sincerely,

Rebekah Moon

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

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Wichita
Steve Kelly, Public Member
Newton
Gerald O. Minns, MD
Bel Aire

Kansas HCSF Provider Compliance Information

ANNE S MOORE MD 116254

"HCSF Coverage" codes are as follows:

From 7-1-76 to 6-30-84 the Fund coverage was unlimited. Only the "U" code should appear for compliance periods that originated during this period.

From 7-1-84 to 6-30-89 the Fund coverage was $3million/$6million. Only the "T" code should appear for compliance periods that originated during this period.

From 7-1-89 to current optional Fund coverage limits were available to health care providers. Code "8" means HCSF Coverage Limits of $800,000/$2.4million. Code "3" means HCSF coverage limits of $300,000/$900,000. Code "1" means HCSF coverage limits of $100,000/$300,000.

Effective Date	Expiration Date	Coverage Level Code	Company Name
10/3/2018	7/1/2019	8	NATIONAL FIRE & MARINE INS CO.

IMPORTANT COPY
Record of HCSF Compliance
HEALTH CARE STABILIZATION FUND

EXHIBIT
tabbies
5

RECEIVED
By KSBHA at 3:52 pm, Feb 25, 2020

Print Form

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 - 41515 ☒ Medicine & Surgery ☐ Chiropractic ☐ Osteopathic ☐ Podiatry

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

Name: Anne (First) S Moore
CONFIDENTIAL

Home Address:

Home Telephone

Business Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Business Telephone Number: ____ - ____ - ____ E-Mail Address: _____

Preferred Mailing Address: ☐ Home ☐ Business

EFFECTIVE 3 / 1 / 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 12

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

☐ **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.

Anne Schell Moore 2-25-2020
Signature Date

Print Form

revised 3/6/19