

EFFECTIVE AS A FINAL ORDER

DATE: 4/6/2020

FILED

MAR 16 2020

BEFORE THE BOARD OF HEALING ARTS OF THE STATE OF KANSAS

KS State Board of Healing Arts

In the Matter of

Docket No. 20-HA00064

Vincent J. Nardone, M.D.
Kansas License No. 04-42154

AMENDED SUMMARY ORDER

NOW ON THIS 16th 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 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. Vincent J. Nardone, M.D. ("Licensee") was issued License No. 04-42154 to practice medicine and surgery on May 21, 2019. On or about March 4, 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:

Amended Summary Order
Vincent J. Nardone, M.D.
Docket No. 20-HA00064

- a. On or about February 25, 2019, Licensee applied for an Active license. (Exhibit 1.)
- b. After Licensee was granted an Active license on May 21, 2019, a search of the KHCSF showed Licensee was not in compliance with the Kansas Healthcare Stabilization Fund (“KHCSF”).
- c. Licensee was not in compliance with the KHCSF from May 21, 2019 up to and until August 7, 2019; from September 13, 2019, up to and until September 22, 2019; and from October 29, 2019, up to and until February 11, 2020.
- d. On September 16, 2019, and October 18, 2019, the Board requested Licensee to provide proof of compliance with the Kansas Health Care Stabilization Fund (“KHCSF”), as required by K.S.A. 40-3404. The Board included instructions on how to contact KHCSF and warned that a failure to provide proof of compliance may result in a fine or suspension of Licensee’s license to practice medicine in Kansas. (Exhibit 2 and 3.)
- 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 4.)
- g. Licensee was previously out of compliance with the KHCSF since on or about May 21, 2019 to August 7, 2019; from September 13, 2019, to September 22, 2019, and

from October 28, 2019 until at least February 11, 2020, while holding an Active license to practice medicine and surgery in Kansas.

- h. On or about March 4, 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 5.)

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 16th 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 16th day of April 2020 by depositing the same in the United States Mail, first-class, postage prepaid, and addressed to:

Vincent J. Nardone, M.D.
CONFIDENTIAL

Licensee

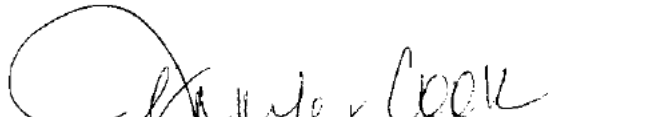
And a copy was hand-delivered to:

J. Todd Hiatt, Litigation Counsel
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

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

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



Jennifer Cook, Paralegal

UA

UNIFORM APPLICATION
FOR PHYSICIAN
STATE LICENSURE

Uniform Application -- Core Application

Applicant: Follow the instructions given in the left sidebar of each page.
Send this application to the Kansas State Board of Healing Arts,
800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

EXHIBIT

tabler

Indicate your full legal name and any other names you have used in the past. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change to the Board.

Please complete all fields and indicate which address you want to use for public access and at which address you want to receive mailings from the Board. State laws vary on which address or phone number is or is not a matter of public record. Additionally, many state boards publish the Public Access address on their web sites. You may wish to contact the appropriate state licensing authority to determine which information will be a matter of public record.

If you are not using FCVS, you must submit one of the following to the Board: certified birth certificate, notarized copy of your birth certificate, original valid passport, or notarized copy of your current valid passport. Please check the state specific instructions for more information.

Be sure to list your name at the top of each following page.

Full Name

Last name: Nardone Suffix: _____
First name: Vincent
Middle name: John
Maiden name (if applicable): _____
All other names used/identified as: _____
Degree Type ☒ M.D. ☐ D.O.

Practice Address

☒ Public Access ☐ Mailings for Medical Board
Street: 1807 Huguenot Road Suite 117
City: Midlothian
State/Province: Virginia
Zip code: 23113 Country: USA
Practice phone: 804-506-0526 Practice fax: _____
Alternate phone: _____ Alternate fax: _____
Practice email: _____

Home Address

☐ Public Access ☒ Mailings for Medical Board
Street: CONFIDENTIAL
City: _____
State/Province: Virginia
Zip code: 23219 Country: USA
Home phone: CONFIDENTIAL Home fax: _____
Alternate phone: _____ Alternate fax: _____
Home email: CONFIDENTIAL

Identification

Date of birth: CONFIDENTIAL Gender: M Birth city: Meriden
Birth state/province: Connecticut Birth country: USA
Social Security number*: CONFIDENTIAL (9 digits) JPI number**: 1720490683 (10 digits) U.S. Citizen? ☒ Yes ☐ No

*Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

**The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, visit <http://www.cms.hhs.gov/NationalProviderIdentStand/>

RECEIVED
FEB 20 2019

Applicant Name:

Vincent Nardone

List all medical schools you have attended, even those from which you did not graduate, in chronological order. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Medical Education Verification form and send it to all medical schools you have attended. Include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to the Board.

Additionally, the medical school must provide the Board with an official copy of your transcripts. If transcripts are not in English, an original, certified, and official English translation is required.

If you attended a Fifth Pathway program and are not using FCVS, you must complete the Fifth Pathway Verification form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to the Board.

If ECFMG is applicable and you are not using FCVS, contact ECFMG and have a certified status report forwarded from them to the Board. There is a separate fee for this report.

Medical School

1. Full Name of Medical School: Virginia Commonwealth University School of Medicine
Street: 1201 East Marshall St
City: Richmond State/Province: Virginia Zip code: 23298
Country: USA Attendance dates: From 08/2008 to 05/2013
(mm/yyyy) (mm/yyyy)
Date degree conferred/issued (indicate if not applicable): 05/10/2013
(mm/dd/yyyy)
Degree received (as stated on diploma): Medical Doctor
(indicate if not applicable)
2. Full Name of Medical School: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Attendance dates: From _____ to _____
(mm/yyyy) (mm/yyyy)
Date degree conferred/issued (indicate if not applicable): _____
(mm/dd/yyyy)
Degree received (as stated on diploma): _____
(indicate if not applicable)

Fifth Pathway

- ☒ I did not participate in a Fifth Pathway program.

Affiliated medical school that awarded the Fifth Pathway Certification

Full Name of Medical School: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Attendance dates: From _____ to _____
(mm/yyyy) (mm/yyyy)
Date degree conferred/issued: _____ Degree (as stated on diploma): _____
(mm/dd/yyyy)

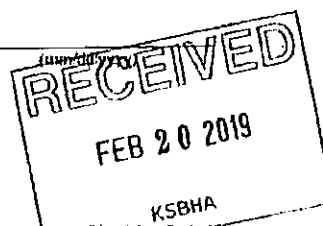
Hospital or clinic in which you performed the required rotations

Institution name: _____
Rotation dates: From _____ to _____ Certificate date: _____
(mm/yyyy) (mm/yyyy) (mm/dd/yyyy)

ECFMG

- ☒ I do not have an ECFMG certificate.

Certificate number: _____ Issue date: _____



Applicant Name:

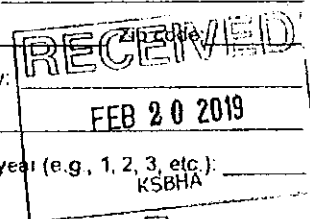
Vincent Nardone

List all postgraduate programs you have attended, even those you did not complete. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Postgraduate Training Verification form and send it to all postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to the Board. The postgraduate program must forward all documentation directly to the Board.

Postgraduate Training

1. Full Name of Hospital: Chippenham and Johnson Willis Hospital
Street: 7101 Jahnke Road
City: Richmond State/Province: Virginia Zip code: 23225
Country: USA Department/Specialty: Family Medicine
Affiliated medical school name: VCU School Of Medicine
Attendance dates: From 07/2014 to 06/2017 Postgraduate year (e.g., 1, 2, 3, etc.): 1-3
(mm/yyyy) (mm/yyyy)
☐ Chief Resident ☒ Internship/Residency ☐ Residency ☐ Transitional
☐ Fellowship ☐ Junior Registrar ☐ Residency/Chief Residency
☐ Fellowship/Research ☐ Preliminary ☐ Senior House Officer ☐ Unknown
☐ House Officer ☐ Registrar ☐ Senior Registrar ☐ Unspecified
☐ Internship ☐ Research ☐ Other: _____
Successfully completed? ☒ Yes ☐ No ☐ In progress; expected completion in _____ (mm/yyyy)
2. Full Name of Hospital: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Department/Specialty: _____
Affiliated medical school name: _____
Attendance dates: From _____ to _____ Postgraduate year (e.g., 1, 2, 3, etc.): _____
(mm/yyyy) (mm/yyyy)
☐ Chief Resident ☐ Internship/Residency ☐ Residency ☐ Transitional
☐ Fellowship ☐ Junior Registrar ☐ Residency/Chief Residency
☐ Fellowship/Research ☐ Preliminary ☐ Senior House Officer ☐ Unknown
☐ House Officer ☐ Registrar ☐ Senior Registrar ☐ Unspecified
☐ Internship ☐ Research ☐ Other: _____
Successfully completed? ☐ Yes ☐ No ☐ In progress; expected completion in _____ (mm/yyyy)
3. Full Name of Hospital: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Department/Specialty: _____
Affiliated medical school name: _____
Attendance dates: From _____ to _____ Postgraduate year (e.g., 1, 2, 3, etc.): _____
(mm/yyyy) (mm/yyyy)
☐ Chief Resident ☐ Internship/Residency ☐ Residency ☐ Transitional
☐ Fellowship ☐ Junior Registrar ☐ Residency/Chief Residency
☐ Fellowship/Research ☐ Preliminary ☐ Senior House Officer ☐ Unknown
☐ House Officer ☐ Registrar ☐ Senior Registrar ☐ Unspecified
☐ Internship ☐ Research ☐ Other: _____
Successfully completed? ☐ Yes ☐ No ☐ In progress; expected completion in _____ (mm/yyyy)



Applicant Name:

Vincent Nardone

List the information for each licensure exam you have taken, whether U.S. or international (USMLE, LMCC, NBME, etc.).

If you are not using FCVS, you must contact the appropriate examination entity and have them send a certified transcript of your scores directly to the Board.

Examination History

Examination	Most recent date taken (mm/yyyy)	Passed/Failed/Unknown	Number of attempts
FLEX Pre-1985		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
FLEX Component 1		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
FLEX Component 2		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
LMCC - Single		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
LMCC - Part I		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
LMCC - Part II		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
NBME Part I		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
NBME Part II		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
NBME Part III		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
SPEX		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
NBOME Part I		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
NBOME Part II		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
NBOME Part III		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
COMLEX-USA Level 1		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
COMLEX-USA Level 2, CE		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
COMLEX-USA Level 2, PE		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
COMLEX-USA Level 3		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
COMVEX		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
USMLE Step I	06/2011	<input checked="" type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	2
USMLE Step II, CS	09/2012	<input checked="" type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	1
USMLE Step II, CK	09/2012	<input checked="" type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	1
USMLE Step III	06/2015	<input checked="" type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	1
State Board Exam			
State: _____		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
State: _____		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
State: _____		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	
State: _____		<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	

List all state and Canadian provinces where you currently hold or have ever held any type of health care related license. Please copy and attach additional pages if necessary.

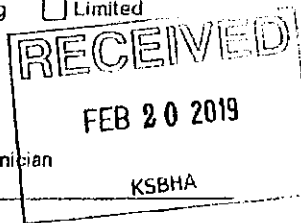
You must also complete the Licensure Verification form and send it to all states in which you have held any health care license or certification. Some state boards charge a fee for this information. The verifying entity must forward all licensure documentation to the Board.

State/Province Professional Licensure

1. Practitioner license type: ☒ Full license ☐ Temporary ☐ Training ☐ Limited
- ☒ Doctor of Medicine ☐ Nurse Practitioner
- ☐ Doctor of Osteopathic Medicine ☐ Licensed Practical Nurse
- ☐ Doctor of Dental Surgery ☐ Registered Nurse
- ☐ Doctor of Dental Medicine ☐ Physician Assistant
- ☐ Doctor of Psychology ☐ Emergency Medical Technician
- ☐ Doctor of Podiatric Medicine ☐ Other (please specify) _____
- ☐ Doctor of Chiropractic

State/Province: VirginiaLicense number: 0101259297Issue date: 11/04/2015

License status:

☒ Active☐ Expired☐ In Good Standing☐ Inactive☐ Limited☐ Probationary☐ Restricted☐ Retired☐ Revoked☐ Suspended

Applicant Name:

Vincent Nardone

Please copy and attach additional pages if necessary.

2. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine ☐ Nurse Practitioner
☐ Doctor of Osteopathic Medicine ☐ Licensed Practical Nurse
☐ Doctor of Dental Surgery ☐ Registered Nurse
☐ Doctor of Dental Medicine ☐ Physician Assistant
☐ Doctor of Psychology ☐ Emergency Medical Technician
☐ Doctor of Podiatric Medicine ☐ Other (please specify) _____
☐ Doctor of Chiropractic

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Expired ☐ In Good Standing
☐ Inactive ☐ Limited ☐ Probationary
☐ Restricted ☐ Retired ☐ Revoked ☐ Suspended

3. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine ☐ Nurse Practitioner
☐ Doctor of Osteopathic Medicine ☐ Licensed Practical Nurse
☐ Doctor of Dental Surgery ☐ Registered Nurse
☐ Doctor of Dental Medicine ☐ Physician Assistant
☐ Doctor of Psychology ☐ Emergency Medical Technician
☐ Doctor of Podiatric Medicine ☐ Other (please specify) _____
☐ Doctor of Chiropractic

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Expired ☐ In Good Standing
☐ Inactive ☐ Limited ☐ Probationary
☐ Restricted ☐ Retired ☐ Revoked ☐ Suspended

4. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine ☐ Nurse Practitioner
☐ Doctor of Osteopathic Medicine ☐ Licensed Practical Nurse
☐ Doctor of Dental Surgery ☐ Registered Nurse
☐ Doctor of Dental Medicine ☐ Physician Assistant
☐ Doctor of Psychology ☐ Emergency Medical Technician
☐ Doctor of Podiatric Medicine ☐ Other (please specify) _____
☐ Doctor of Chiropractic

State/Province: _____ License number: _____ Issue date: _____

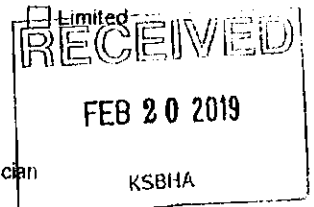
License status: ☐ Active ☐ Expired ☐ In Good Standing
☐ Inactive ☐ Limited ☐ Probationary
☐ Restricted ☐ Retired ☐ Revoked ☐ Suspended

5. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine ☐ Nurse Practitioner
☐ Doctor of Osteopathic Medicine ☐ Licensed Practical Nurse
☐ Doctor of Dental Surgery ☐ Registered Nurse
☐ Doctor of Dental Medicine ☐ Physician Assistant
☐ Doctor of Psychology ☐ Emergency Medical Technician
☐ Doctor of Podiatric Medicine ☐ Other (please specify) _____
☐ Doctor of Chiropractic

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Expired ☐ In Good Standing
☐ Inactive ☐ Limited ☐ Probationary
☐ Restricted ☐ Retired ☐ Revoked ☐ Suspended



Applicant Name:

Vincent Nardone

List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, indicating month and year.

*Also list your permanent or home address for each non-working time.

If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.

DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS SECTION.

Copy and attach additional pages as necessary.

** Clinical indicates the percentage of time spent with patients.

*** Administrative indicates the percentage of time spent on administrative tasks like paperwork, etc.

Chronology of Activities

1. Start date: 05/2013 End date: 06/2014
(mm/yyyy) (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons)
☐ Military service ☒ Postgraduate training/education
☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: _____
Virginia Commonwealth University-studied towards a MS in Biostatistics and Clinical Research

Street: 1201 East Marshall St
City: Richmond State/Province: Virginia Zip code: 23298
Country: USA Position: Masters Student
Department: Biostatistics Clinical**: 0 % Administrative***: 100 %

☐ Employment ☐ Staff Privileges ☐ Affiliation
☒ Other (describe your relationship with this institution): Student

2. Start date: 07/2014 End date: 06/2017
(mm/yyyy) (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons)
☐ Military service ☒ Postgraduate training/education
☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: _____
Chesterfield Family Medicine Residency-Chippenham and Johnson Willis Hospitals

Street: 2500 Pocoshock Pl
City: Richmond State/Province: Virginia Zip code: 23235
Country: USA Position: Family Medicine Resident
Department: Family Medicine Clinical**: 80 % Administrative***: 20 %

☒ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution): _____

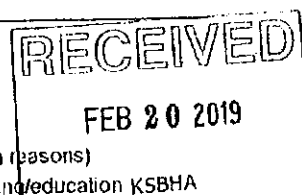
3. Start date: 01/2016 End date: Current
(mm/yyyy) (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons)
☐ Military service ☐ Postgraduate training/education KSBHA
☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name or Description of non-working time*: _____
Foundation Medical Group

Street: 1807 Huguenot Road Suite 117
City: Richmond State/Province: Virginia Zip code: 23113
Country: USA Position: Addiction Medicine Physician/Medical Director
Department: Addiction Medicine Clinical**: 80 % Administrative***: 20 %

☒ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution): _____



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



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

Kathleen Selzler Lippert, Executive Director

Laura Kelly, Governor

September 16, 2019

1426066

Vincent John Nardone, MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; 04-42154

Dear Dr. Nardone:

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).

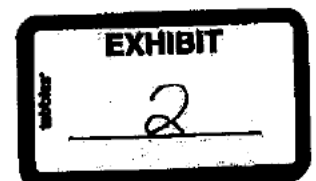
Please provide proof of your: (1) professional liability insurance; and (2) KHCSF compliance for the period for which you renewed your license, on or before **October 16, 2019**. Failure to produce this requested information may result in disciplinary action against your license, including but not limited 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.

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. DURRIETT, DO, GREAT BEND THOMAS ESTEP, MD, WICHITA ANNE HODGSON, PUBLIC MEMBER, LENEXA
JOEL R. HUTCHINS, MD, HOLTON STEVE KELLY, PUBLIC MEMBER, NEWTON DAVID LANA, DPM, OVERLAND PARK DOUGLAS J. MILFELD, MD, WICHITA
GAROLD O. MINNS, MD, BELAIRE KIMBERLY J. TEMPLETON, MD, LEAWOOD RONALD M. VARNER, DO, EL DORADO

TTY (HEARING IMPAIRED) 711 OR 1.800.769.3777 VOICE/TTY E-MAIL: KSBHA_HEALINGARTS@KS.GOV



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

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

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

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

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

Sincerely,

Rebekah Moon

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

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

TTY (HEARING IMPAIRED) 711 OR 1.800.768.3777 VOICE/TTY E-MAIL: KSBHA_HEALINGARTS@KS.GOV

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



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

October 18, 2019

Final Notice

1426066

Vincent John Nardone MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; Final Notice; 04-42154

Dear Dr. Vincent John Nardone:

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:

Sтивен J. Gould, DC, President
Chaney
R. Jerry DeGruccio, DC
Wichita
Anne Hodgdon, Public Member
Lenexa
David Laha, DPM
Overland Park
Kimberly J. Templeton, MD
Leawood

John F. Setlich, Ph.D., Public Member, Vice President
Alchison
Robin D. Durrett, DO
Great Bend
Joel R. Hutchins, MD
Horton
Douglas J. Milfeld, MD
Wichita
Ronald M. Vamer, DO
Augusta

Mark Balderston, DC
Shawnee
Tom Estep, MD
Wichita
Steve Kelly, Public Member
Newton
Gerald O. Minns, MD
Bel Aire

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

Kansas HCSF Provider Compliance Information

VINCENT J NARDONE MD

118534

"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
9/23/2019	10/28/2019	8	PROASSURANCE SPECIALTY INSURANCE COMPANY INC
8/8/2019	9/12/2019	8	PROASSURANCE SPECIALTY INSURANCE COMPANY INC

IMPORTANT COPY
Record of HCSF Compliance
HEALTH CARE STABILIZATION FUND



Tuesday, February 11, 2020

11:35 AM

Page 1 of 1



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 - 42154 ☒ Medicine & Surgery ☐ Chiropractic ☐ Osteopathic ☐ Podiatry
Current Type: ☒ Active ☐ Federal Active ☐ Military ☐ Exempt ☐ Inactive

Name: Vincent
First

John

CONFIDENTIAL

Alameda

Home Address:

Home Telephone:

Business Address: 1807 Huguenot Road Midlothian VA 23113
Street City State Zip

CONFIDENTIAL

Business Telephone Number: 804 - 506 - 0526 E-Mail Address:

Preferred Mailing Address: ☒ Home ☐ Business

EFFECTIVE 03 / 04 / 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

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 hours on the Kansas Board of Health's website www.ksbha.org.

4. If you have a professional liability claim?

Has a professional liability claim been filed against you?
If so, please indicate the date of the claim and whether it was settled or surrendered or

EXHIBIT

5

www.ksbha.org

☐ **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 fee schedule on the back of this form.

Current Type of:

I certify under penalty of perjury that the information provided on this application is true and correct, and I am attaching supporting documentation as required.

Vincent Williams
Signature