

EFFECTIVE AS A FINAL ORDER

DATE: 3/31/2020

FILED
MAR 11 2020 AD

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

KS State Board of Healing Arts

In the Matter of

Docket No. 20-HA 00078

**Mark A. Osborne, M.D.
Kansas License No. 04-42054**

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. Mark A. Osborne, M.D. ("Licensee") was issued License No. 04-42054 to practice medicine and surgery on April 24, 2019. Licensee's license status is currently Exempt, having changed his status on March 3, 2020.

2. Licensee's last known mailing address to the Board is:

CONFIDENTIAL

CONFIDENTIAL

3. During all times relevant to the facts set forth in this Summary Order, Licensee held an Active license to practice medicine and surgery in Kansas.

4. The factual basis for this Order is as follows:

**Summary Order
Mark A. Osborne, M.D.**

- a. On or about September 26, 2018, Licensee applied for an Active license that was issued on April 24, 2019. (Exhibit 1.)
- b. On or about June 11, 2019, Licensee renewed his license online as Active. Licensee's renewal application stated that "As a condition of providing professional services in Kansas, whether or not physically located in Kansas, each person with an active license must pay the annual surcharge to the Kansas Health Care Stabilization Fund (KHCSF)." (emphasis in original). Licensee was asked "Have you paid the annual surcharge to the KHCSF?" to which he answered "No." (Exhibit 2.)
- c. After renewing his license, a search of the KHCSF showed Licensee was not in compliance.
- d. On September 16, 2019, and October 18, 2019, the Board requested Licensee to provide proof of compliance with the Kansas Health Care Stabilization Fund ("KHCSF"), as required by K.S.A. 40-3404. The Board included instructions on how to contact KHCSF and warned that a failure to provide proof of compliance may result in a fine or suspension of Licensee's license to practice medicine in Kansas. (Exhibit 3 and 4.)
- e. On November 12, 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. On or about March 3, 2020, Licensee submitted an Application for Change of Designation/Type to the Board requesting that his license status be changed to

Exempt status. On or about March 3, 2020, Licensee's license status was changed to Exempt, making him now compliant with the KHCSF. (Exhibit 6.)

- h. Licensee was previously out of compliance with the KHCSF since his initial licensure on or about April 24, 2019 until at least February 11, 2020, while holding an Active license to practice medicine and surgery in Kansas.

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:

Mark A. Osborne, MD
CONFIDENTIAL

Licensee

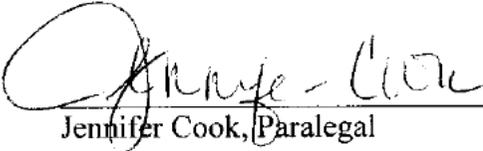
And a copy was hand-delivered to:

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

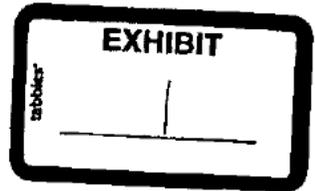
Licensing Administrator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

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, Paralegal



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

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.

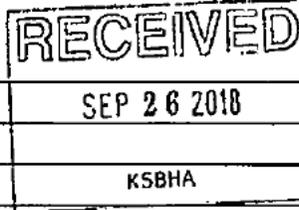
Please complete all fields and indicate which address you want to use for public access and at which address you want to receive mailings from the Board. State laws vary on which address or phone number is or is not a matter of public record. Additionally, many state boards publish the Public Access 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: Osborne Suffix: _____
 First name: Mark
 Middle name: Allen
 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: 1255 S Cedar Crest Blvd
STE 2500
 City: Allentown
 State/Province: PA
 Zip code: 18103 County: _____
 Practice phone: 610-770-1601 Practice fax: _____
 Alternate phone: _____ Alternate fax: _____
 Practice email: _____

Home Address

Public Access
 Mailings for Medical Board

CONFIDENTIAL

Identification

Date of birth: _____ Gender: Male Birth city: GALESBURG, IL
 Birth state/province: IL Birth country: USA
 Social Security number: _____ number: 1922062926 U.S. Citizen? Yes No
(10 digits) (10 digits)

CONFIDENTIAL

CONFIDENTIAL

*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/NationalProviderIdentifier/>

Bhakta, Chandni [BOHA]

From: CONFIDENTIAL
Sent: Tuesday, February 26, 2019 12:15 PM
To: Bhakta, Chandni [BOHA]
Subject: Osborne

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

Hi CONFIDENTIAL

Dr Mark Osborne

Sent from my iPhone

Applicant Name:

MARK OSBORNE MD

PRITZKER

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: UNIV OF CHICAGO SOM

Street: 924 E 57th STREET ST 104

City: CHICAGO State/Province: IL Zip code: 60637

Country: USA Attendance dates: From 07/1977 to 06/1981
(mm/yyyy) (mm/yyyy)

Date degree conferred/issued (indicate if not applicable): 06/01/1981
(mm/dd/yyyy)

Degree received (as stated on diploma): MD
(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

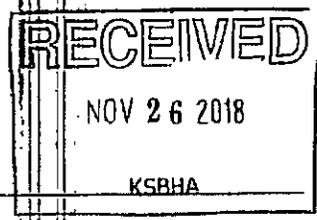
Institution name: _____

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: _____
(mm/dd/yyyy)



Applicant Name:

MARK OSBORNE MD

RECEIVED

NOV 26 2018

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: ST MARYS MEDICAL CENTER (SCHOOL)
 Street: 450 STANNAN STREET
 City: SAN FRANCISCO State/Province: CA Zip code: 94117
 Country: USA Department/Specialty: RADIOLOGY
 Affiliated medical school name: _____
 Attendance dates: From 07/1981 to 06/1982 Postgraduate year (e.g., 1, 2, 3, etc.): 2
 (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: DUKE UNIVERSITY
 Street: DUMC 3951
 City: DURHAM State/Province: NC Zip code: 27710
 Country: USA Department/Specialty: RADIOLOGY
 Affiliated medical school name: _____
 Attendance dates: From 07/1982 to 06/1986 Postgraduate year (e.g., 1, 2, 3, etc.): 2
 (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: TUFTS UNIVERSITY
 Street: 136 HARRISON AVE
 City: BOSTON State/Province: MA Zip code: 02111
 Country: USA Department/Specialty: MRI
 Affiliated medical school name: _____
 Attendance dates: From 07/1986 to 06/1987 Postgraduate year (e.g., 1, 2, 3, etc.): 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)

Applicant Name:

MARK A. OSBORNE MD

RECEIVED

SEP 26 2018

List the information for each licensure exam you have taken, whether U.S. or International (USMLE, LLMCC, 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

Table with columns: Examination, Most recent date taken (mm/yyyy), Passed/Failed/Unknown (with checkboxes for P, F, U), Number of attempts.

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

SEE ATTACHED LIST

1. Practitioner license type: [X] 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)
State/Province: License number: Issue date:
License status: [] Active [] Expired [] In Good Standing
[] Inactive [] Limited [] Probationary
[] Restricted [] Retired [] Revoked [] Suspended

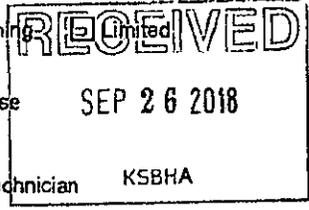
Mark A. Osborne MD
Licenses Held
9/2018



State Board	License #	Date Issued	Date of Expiration
PA	MD038402E	06/10/1987	12/31/2018.
UT	7014418-1205	08/18/2008	Inactive
IN	01065661A	07/25/2008	10/31/2019
IL	036120565	04/14/2008	07/31/2020
KY	42387	07/20/2017	02/28/2019
TN	43276	03/31/2008	Inactive
NC	29017	07/12/1982	Inactive
VA	0101243942	06/25/2008	Inactive
MA	55845	Unknown	Inactive
MT	58509	06/19/2017	03/31/2019
ID	M-13667	03/07/2017	06/30/2020
IA	MD-44305	04/25/2017	09/01/2019
WY	TL3976	05/19/2017	renewal in process
NM	MD2017-0494	06/01/2017	07/01/2021
NE	30118	06/20/2017	10/01/2018 - Renewal in process
AZ	53274	12/20/2017	09/19/2019
CA	G153071	12/20/2017	09/30/2019

Applicant Name: MARK OSBORNE MD

Please copy and attach additional pages if necessary.



2. Practitioner license type: Full license Temporary Training Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> 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

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> 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

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> 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

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> 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: MARK OSBORNE MD

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: 07/1981 End date: 6/1982
(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*: ST MARV'S MEDICAL SCHOOL

Street: 450 STANYAN STREET

City: SAN FRANCISCO State/Province: CA Zip code: 94117

Country: USA Position: INTERNSHIP

Department: RADIOLOGY Clinical**: 100% Administrative***: 0%

Employment Staff Privileges Affiliation
 Other (describe your relationship with this institution): INTERNSHIP

2. Start date: 7/1982 End date: 06/1986
(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*: DUKE UNIVERSITY

Street: DUMC 3951

City: DURHAM State/Province: NC Zip code: 27710

Country: USA Position: RESIDENCY

Department: MRI Clinical**: 100% Administrative***: 0%

Employment Staff Privileges Affiliation
 Other (describe your relationship with this institution): RESIDENCY

3. Start date: 07/1986 End date: 04/1987
(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*: TUFTS UNIVERSITY

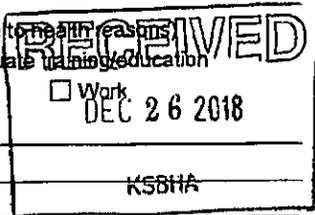
Street: 136 HARRISON AVE

City: BOSTON State/Province: MA Zip code: 02111

Country: USA Position: FELLOWSHIP

Department: MRI Clinical**: 100% Administrative***: 0%

Employment Staff Privileges Affiliation
 Other (describe your relationship with this institution): FELLOWSHIP



Applicant Name: MARK OSBORNE MD

Copy and attach additional pages as necessary.

4. Start date: 07/1987 End date: PRESENT
(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*:
MEDICAL IMAGING OF LEHIGH VALLEY

Street: 1255 S CEDAR CREST BLVD ST 13600
City: ALLENTOWN State/Province: PA Zip code: 18103
Country: USA Position: RADIOLOGIST
Department: RADIOLOGY Clinical**: 100% Administrative***: %

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

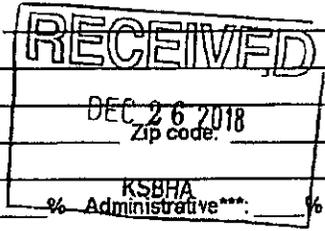
5. Start date: _____ End date: _____
(mm/yyyy) (mm/yyyy)

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*: _____

Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Position: _____
Department: _____ Clinical**: _____% Administrative***: _____%

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



6. Start date: _____ End date: _____
(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*: _____

Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Position: _____
Department: _____ Clinical**: _____% Administrative***: _____%

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

Please copy and attach additional pages as necessary.

Applicant Name:

MARK OSBORNE MD

RECEIVED

SEP 26 2018

KSBHA

You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information #2

I have not had any malpractice claims or suits made against me. CONFIDENTIAL

1. Name of patient involved: _____

In which state, territory, or province did the action take place? PA

Which court? LEHIGH COUNTY, PA

Case number (if applicable) _____

Month and year of lawsuit: 12/2005

Month and year of event precipitating claim: 10/2006

Current claim status:

Closed (settled)

Dismissed (no money paid out)

Open (pending) CONFIDENTIAL

Other: _____ CONFIDENTIAL

Amount of judgment or settlement: \$ TIAL

Amount paid on your behalf: \$ TIAL

What is/was your status?

Primary Defendant

Co-Defendant

Other (specify): _____

Insurance carrier at the time: _____

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

CONFIDENTIAL

Complete the forms on the following pages as instructed.

UA Affidavit and Authorization for Release of Information

UA Form #1: Licensure Verification Form

All state-specific forms included with this core application

If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

UA Form #2: Medical School Verification

UA Form #3: Postgraduate Training Verification

UA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

Applicant Name:

MARK OSBORNE MD

RECEIVED

SEP 26 2018

KSBHA

You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

3

I have not had any malpractice claims or suits made against me. CONFIDENTIAL

1. Name of patient involved:

In which state, territory, or province did the action take place? PA

Which court? LEHIGH COUNTY, PA

Case number (if applicable) _____ Month and year of lawsuit: 6/1989

Month and year of event precipitating claim: 11/14/91

Current claim status: Closed (settled) Dismissed (no money paid out) Open (pending) Other: CONFIDENTIAL

Amount of judgment or settlement: \$ _____ Amount paid on your behalf: \$ _____ TIAL

What is/was your status? Primary Defendant Co-Defendant Other (specify): _____

Insurance carrier at the time: _____

Please provide specifics in reference to the adverse event, including the allegations and your role in the event in the space below. CONFIDENTIAL

Complete the forms on the following pages as instructed.

- UA Affidavit and Authorization for Release of Information
- UA Form #1: Licensure Verification Form
- All state-specific forms included with this core application

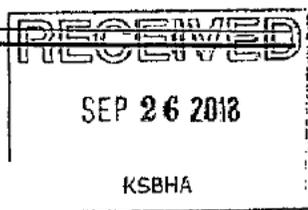
If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

- UA Form #2: Medical School Verification
- UA Form #3: Postgraduate Training Verification
- UA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

Applicant Name: MARK OSBORNE MD



You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

*4

I have not had any malpractice claims or suits made against me. **CONFIDENTIAL**

1. Name of patient involved: _____

In which state, territory, or province did the action take place? PA

Which court? LEHIGH COUNTY, PA

Case number (if applicable) _____ Month and year of lawsuit: 4/92

Month and year of event precipitating claim: 3/90

Current claim status: Closed (settled) Dismissed (no money paid out) Open (pending) Other: 6/14/99 **CONFIDENTIAL**

Amount of judgment or settlement: \$ _____ Amount paid on your behalf: \$ _____ **CONFIDENTIAL**

What is/was your status? Primary Defendant Co-Defendant Other (specify): _____

Insurance carrier at the time: _____

Please provide specifics in reference to the adverse event, including the allegations and your role in the event in the space below. Use another sheet of paper or the back of this form if necessary. **CONFIDENTIAL**

Complete the forms on the following pages as instructed.

- JA Affidavit and Authorization for Release of Information
- JA Form #1: Licensure Verification Form
- All state-specific forms included with this core application

If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

- JA Form #2: Medical School Verification
- JA Form #3: Postgraduate Training Verification
- JA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

Applicant Name: MARK OSBORNE MD

You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

\$5

RECEIVED
SEP 26 2018
KSBHA

I have not had any malpractice claims or suits made against me.

CONFIDENTIAL

1. Name of patient involved: _____

In which state, territory, or province did the action take place? PA

Which court? LEHIGH COUNTY, PA

Case number (if applicable) _____ Month and year of lawsuit: 10/96

Month and year of event precipitating claim: UNKNOWN

Current claim status: Closed (settled) Dismissed (no money paid out)
 Open (pending) Other: _____

CONFIDENTIAL

Amount of judgment or settlement: \$ _____ Amount paid on your behalf: \$ _____

What is/was your status? Primary Defendant Co-Defendant
 Other (specify): _____

Insurance carrier at the time: _____

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

CONFIDENTIAL

Complete the forms on the following pages as instructed.

- UA Affidavit and Authorization for Release of Information
- UA Form #1: Licensure Verification Form
- All state-specific forms included with this core application

If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

- UA Form #2: Medical School Verification
- UA Form #3: Postgraduate Training Verification
- UA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

KSBOHA Online Renewal Application

Date Created:

Tuesday, June 11, 2019

Name:

Mark Allen Osborne

License Information

License Number:

04-42054

License Type:

Medical Doctor (MD)

Status Before Renewal:

Active

Status After Renewal:

Active

Status Change Date:

Birth Date:

CONFIDENTI

Gender:

AL

Citizenship Status:

M

Ethnicity:

U.S. Citizen

Address Information:

Use Primary Business Address for mailing:

N

Residence Address:	CONFIDENTIAL
Line 1:	
Line 2:	
City, State, Zip:	
Country:*	
Phone:	
Email:*	
Primary Business Address:	
Line 1:	1255 S Cedar Crest Blvd
Line 2:	Ste 2500
City, State, Zip:	Allentown, PA 18103
Country:*	United States
Phone:	6107701606
Email:*	maosbomemd@gmail.com

Insurance Information:

Medical Mutual Insurance of North Carolina	Add	
Policy Number:	PG120369	Malpractice Insurance
Insurance Issue Date:	1/1/2019	
Insurance Exp Date:	1/1/2020	

Exempt - Professional Activities

Professional activity	Description



Applicant Questions

Retirement

Planning to retire within 5 years?
N

Dispensing

Dispense Pharmaceuticals
N

Malpractice Screening Panel

I am willing to serve on a Screening Panel
N

No Practice Address

I certify that I do NOT practice in Kansas:
Y

Expert Witness

I am willing to serve as an expert for the Board
N

Supervise Non-Licensed Rad Techs

I supervise non-licensed rad techs	I certify that they are trained on the equipment	I certify that they have/will obtain continuing ed
N	N	N

Board Certifications

Certifying Board	Other Board
ABR-American Board of Radiology	

Kansas Hospital Privileges

Hospital/Surgery Center	Other Hospital
-------------------------	----------------

DEA Number

DEA Number

Identify all other authorities that have ever licensed you to practice.

Other State Licenses Ever Held

Other State	Date Issued
AZ	Dec 20 2017 12:00AM
CA	Dec 7 2017 12:00AM
ID	Mar 7 2017 12:00AM
IL	Apr 14 2008 12:00AM
IN	Jul 25 2008 12:00AM
IA	Dec 22 2008 12:00AM
IA	Apr 25 2017 12:00AM
KY	Dec 23 2008 12:00AM
MT	Jun 29 2017 12:00AM
MT	Oct 27 2001 12:00AM
NE	Jun 20 2017 12:00AM
NM	Jun 1 2017 12:00AM
NC	Jul 12 1982 12:00AM
NC	May 4 1985 12:00AM
PA	Jun 10 1987 12:00AM
TN	Mar 31 2008 12:00AM
UT	Aug 18 2008 12:00AM
VA	Jun 25 2008 12:00AM
WY	Jul 14 2017 12:00AM
WY	May 19 2017 12:00AM
MA	May 28 1986 12:00AM
SC	Dec 31 2018 12:00AM

National Provider Identifier

NPI Number	I do not currently have a NPI #:
1922062926	

Language

English	Spanish	ASL (American Sign Language)	Other Languages
Y	N	N	

Disaster Relief

Please do not include me in the registry	Within My County	Within 75 Miles	Anywhere in Kansas	Outside the State of Kansas
N	N	Y	N	Y

CE Year

Education Year

2020

Question Responses

Continuing Education Questions	
Does your "Education Year" listed above indicate that you do not have continuing education hours due at this time?	Y
Do you have at least 50 total hours of continuing education with a minimum of 20 Category I & a maximum of 30 Category II from 01-01-2018 through 06-30-2019?	N
Do you have at least 100 total hours of continuing education with a minimum of 40 Category I & a maximum of 60 Category II from 01-01-2017 through 06-30-2019?	N
Do you have at least 150 total hours of continuing education with a minimum of 60 Category I & a maximum of 90 Category II from 01-01-2016 through 06-30-2019?	N
Continuing Education Audit Question	
The Board will verify compliance with continuing education requirements in an undetermined percentage of renewal applications. This verification will involve an audit of records maintained by the licensee. You must maintain your continuing education records for a three year period in a manner that allows them to be readily produced. Do you understand the audit process?	Y
Gratuitous Professional Services	
Have you entered into an agreement with the Kansas Secretary of Health and Environment to gratuitously provide professional services to medically indigent persons or to conduct a children's immunization program administered by the Kansas Secretary of Health and Environment?	N
Have you gratuitously provided any professional services at a local health department or indigent healthcare clinic to a medically indigent person or a person receiving medical assistance from the programs operated by the department of health and environment?	N
If you answered in the affirmative to either of the preceding questions, how many hours of gratuitous services to medically indigent persons have you provided within the preceding licensure period? If you answered "No" above, enter "NA".	na
How many hours of continuing education credit (by the performance of two hours of gratuitous professional services to medically indigent persons per hour claimed), up to a maximum of twenty (20) hours of continuing education credit, are you claiming for this licensure period? If you answered "No" above, enter "NA".	na
KHCSF Compliance	
As a condition of providing professional services in Kansas, whether or not physically located in Kansas, each person with an active license must pay the annual surcharge to the Kansas Health Care Stabilization Fund (KHCSF).	N
Have you paid the annual surcharge to the KHCSF?	
KTRACS	
Are you enrolled in the Prescription Drug Monitoring Program (K-TRACS)? (see www.kansas.gov/pharmacy)	N
I know what K-TRACS is.	N
I am unsure of how to enroll in K-TRACS.	Y
K-TRACS is clinically useful for me.	N
K-TRACS is cumbersome to use.	N
I prescribe/dispense controlled substances.	N
Office Based Surgery	
In Kansas, have you since your last renewal, performed procedures in your office that require sedation, including IV sedation of any kind: inhaled agents; parenteral, regional, spinal, epidural or general anesthesia. ("Office" as used here does not include a hospital based practice. Also excluded are minor procedures that can be performed safely and comfortably with any one or combination of the following: a low dose oral sedative that does not affect the patient's level of consciousness; local; topical; or no anesthesia.)	N
Office Based Surgery Practice Location: If you answered "Yes" to the above question, enter the location here or if you answered "No" above enter "NA".	NA
Accrediting Entity Name: If you answered "Yes" to the above question, enter the entity name here. If your office is not accredited or if you answered "No" above, enter "NA". Appropriate names are as follows:	
<ul style="list-style-type: none"> • Accreditation Association for Ambulatory Health Care, Inc. • American Association for Accreditation of Ambulatory Surgery Facilities, Inc. • Institute for Medical Quality • Joint Commission on Accreditation of Healthcare Organizations • NA 	NA
Certification/Accreditation Number: If you answered "Yes" to the above question, enter the Certification/Accreditation number here. If your office is not accredited or if you answered "No" above, enter "NA".	NA

Attestation Questions	
A. In the past 12 months have you been and/or continued to be a defendant or has any judgment, award or settlement been paid on your behalf as a result of a professional liability claim/lawsuit?	N
B. In the past 12 months have you been arrested, charged with or convicted of any felony, misdemeanor or the military equivalent? This includes a diversion or plea to a felony, misdemeanor or the military equivalent.	N
C. In the past 12 months has any disciplinary action been initiated or taken against you by any state or government agency, or have you been denied a license, had any adverse action taken on your license, surrendered or consented to limitation of your license to practice in any state or country?	N
D. In the past 12 months have any privileges related to your profession as a health care provider been suspended, restricted, limited or voluntarily surrendered or has any peer review or professional association initiated or taken any action against you?	CONFIDENTIAL
E. In the past 12 months have you suffered from any impairment which might affect your ability to safely practice, been referred to and/or participated in a program for impaired providers?	
F. In the past 12 months have you been the subject of any investigation, including in Kansas, regarding allegations, complaints, or charges by any state licensing agency or other government agency?	N
Voluntary Supplemental Public Statement	
<p>Pursuant to K.S.A. 65-28, 131, on and after July 1, 2010, the board shall make available on a searchable website which shall be accessible by the public, the following information regarding licensees:</p> <p>(1) The licensee's full name, business address, telephone number, license number, type, status and expiration date;</p> <p>(2) the licensee's practice specialty, if any, and board certifications, if any;</p> <p>(3) any public disciplinary action taken against the licensee by the board or by the licensing agency of any state or other country in which the licensee is currently licensed or has been licensed in the past;</p> <p>(4) any involuntary limitation, denial, revocation or suspension of the licensee's staff membership or clinical privileges at any hospital or other health care facility, and the name of the hospital or facility, the date the action was taken, a description of the action, including any terms and conditions of the action and whether the licensee has fulfilled the conditions of the action;</p> <p>(5) any involuntary surrender of the licensee's drug enforcement administration registration; and;</p> <p>(6) any final criminal conviction or plea arrangement resulting from the commission or alleged commission of a felony in any state or country.</p> <p>At the time of licensure or renewal, a licensee may add a statement to such licensee's profile as it appears on the website created herein. Such statement may provide further explanation of any disciplinary information contained in your profile.</p> <p>This statement must be received by the Board within 30 days after your license cancellation date.</p>	
Do you wish to add a statement to further explain any disciplinary information in your public profile?	
Renewer	
Please Enter the Full Name of person completing this renewal.	
Mark A Osborne MD	

Attestation

Pursuant to K.S.A. 65-28, 131, information provided herein may be deemed public and posted on our Website. Failure to furnish the Board any information legally requested by the Board may be deemed unprofessional conduct and may be the basis for disciplinary action.

Pursuant to K.S.A. 65-28, 126, Licensees are required to notify the Kansas State Board of Healing Arts in writing within 30 days of any changes in the licensee's mailing and practice addresses. I certify, under penalty of perjury, that by clicking the "Pay Fees" button I am the person named in this request or have been authorized by that person, and the information I have provided is true, correct and complete to the best of my knowledge. I understand that Kansas Statutes allow the State Board of Healing Arts to revoke, suspend or limit a license, or censure the licensee, or impose a fine in an amount up to \$5,000 for any act of fraud or misrepresentation in applying for renewal of a license.

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

1424842

Mark Allen Osborne MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; 04-42054

Dear Dr. Osborne:

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 KHCSF 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 HODGSON, PUBLIC MEMBER, LENEXA
JDELR. HUTCHINS, MD, HOLTON STEVE KELLY, PUBLIC MEMBER, NEWTON DAVID LAHA, 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 1.800.786.3777 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 HODGDON, PUBLIC MEMBER, LENEXA
JOEL R. HUTCHINS, MD, HOLTON STEVE KELLY, PUBLIC MEMBER, NEWTON DAVID LAHA, DPM, OVERLAND PARK DOUGLAS J. MILFELD, MD, WICHITA
GARDLD O. MINNS, MD, BEL AIRE KIMBERLY J. TEMPLETON, MD, LEAWOOD RONALD M. VARNER, DO, EL DORADO

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

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

Tucker Poling, Interim Executive
Director



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

October 18, 2019

Final Notice

1424842
Mark Allen Osborne, MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; Final Notice; 04-42054

Dear Dr. Mark Allen Osborne:

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

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

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

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

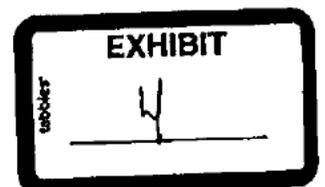
If you are unable to provide a Certificate of Compliance from HCSF, please contact HCSF through the contact information described below. Please remember, once you have obtained your Certificate of Compliance from HCSF, you must then submit a copy of the certification to the Board. Additionally, if you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

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

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

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

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



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

Sincerely,

Rebekah Moon

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

Board Members:

Steven J. Gould, DC, President
Cheney
R. Jerry DeGrado, DC
Wichita
Anne Hodgdon, Public Member
Lenexa
David Laha, DPM
Overland Park
Kimberly J. Templeton, MD
Leawood

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

Mark Balderston, DC
Shawnee
Tom Estep, MD
Wichita
Steve Kelly, Public Member
Newton
Garold O. Mirns, MD
Ber Aire

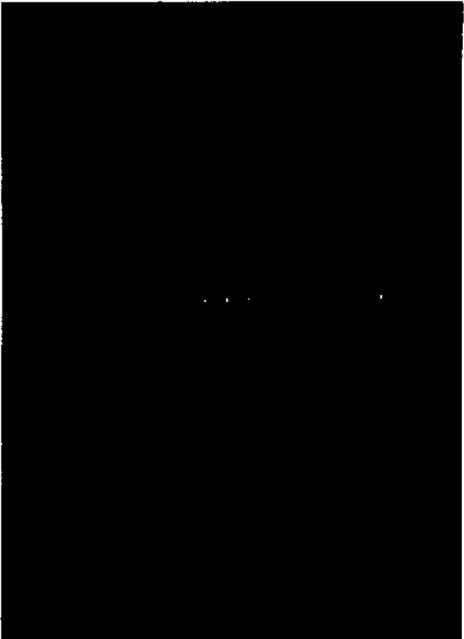
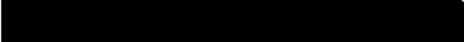
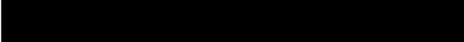
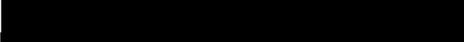
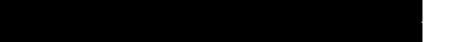
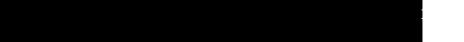
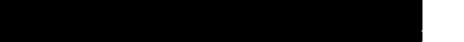
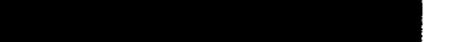
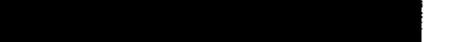
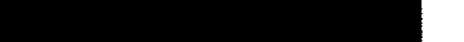
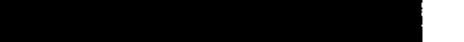
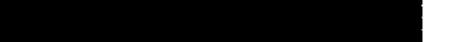
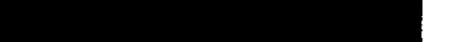
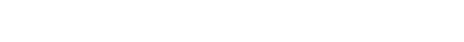
TTY (Hearing Impaired) 711 or 1.800.766.3777 voice/TTY – e-mail: KSBHA_healingarts@ks.gov

Workman, Hester [BOHA]

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

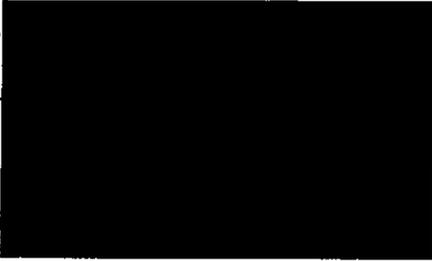
Hester,

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

- | | | |
|-----|---|----------------------|
| 1. |  | No compliance record |
| 2. |  | |
| 3. |  | |
| 4. |  | |
| 5. |  | No compliance record |
| 6. |  | No compliance record |
| 7. |  | No compliance record |
| 8. |  | No compliance record |
| 9. |  | |
| 10. |  | |
| 11. |  | |
| 12. |  | No compliance record |
| 13. |  | |
| 14. |  | No compliance record |
| 15. |  | |
| 16. |  | |
| 17. |  | |
| 18. |  | No compliance record |



19.



No compliance record

20.

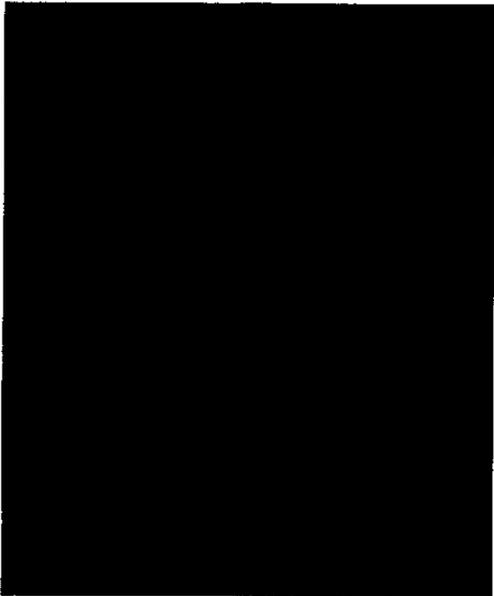
21.

22.

23. Mark Osborne, M.D. 04-42054

No compliance record

24.



25.

No compliance record

26.

27.

28.

29.

30.

31.

32.

Thank you,
Lorie

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



RECEIVED

By KSBHA at 8:44 am, Mar 03, 2020



Kansas

APPLICATION FOR CHANGE OF DESIGNATION/TYPE

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

License No. 04 42054 Medicine & Surgery Chiropractic Osteopathic Podiatry
Current Type: Active Federal Active Military Exempt Inactive

Name: MARK ALIEN OSBORNE
First CONFIDENTIAL
Home Address:

Home Telephone:

Business Address: 1255 CEDAR CREST BLD AWENTOWN PA 18103
Street STE 2500 City State Zip CONFIDENTIAL

Business Telephone Number: 484 350 1012 E-Mail Address:

Preferred Mailing Address: Home Business

EFFECTIVE 3 / 3 / 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 year by reviewing your wallet card or visiting our website www.ksbha.org.

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

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

EXHIBIT
tabbies 4

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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Charitable Health Care Provider | <input type="checkbox"/> Administration |
| <input type="checkbox"/> Treatment of Family and Friends with No Compensation | <input type="checkbox"/> Coroner/Deputy Coroner | <input checked="" type="checkbox"/> None |
| <input type="checkbox"/> 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.

Mari S. Osborn
 Signature

3/3/2020
 Date