

EFFECTIVE AS A FINAL ORDER

DATE: 9.15.20

FILED
AUG 27 2020
KS State Board of Healing Arts

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

In the Matter of

Docket No. 21-HA00006

**Angie R. Taras, M.D.
Kansas License No. 04-41958**

AMENDED SUMMARY ORDER

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

Pursuant to K.S.A 77-537 and K.S.A. 77-542, this Amended Summary Order shall become effective as a Final Order, without further notice, if no written request for a hearing is made within 15 days of service. Upon review of the agency record and being duly advised in the premises, the following findings of fact, conclusions of law, and order are made for and on behalf of the Board:

Findings of Fact

1. Angie R. Taras, M.D. ("Licensee") was issued License No. 04-41958 to practice medicine and surgery on March 20, 2019. On or about June 12, 2020, Licensee renewed her license status to Active.
2. Licensee's last known mailing address to the Board is: **CONFIDENTIAL**
CONFIDENTIAL
3. During all times relevant to the facts set forth in this Summary Order, Licensee held an Active license to practice medicine and surgery in Kansas.
4. The factual basis for this Order is as follows:

**Amended Summary Order
Angie R. Taras, M.D.
KSBHA Docket No. 21-HA00006**

- a. On or about February 14, 2019, Licensee applied for an Active license by and through an Application For Medical Licenses In IMLC Member States. Licensee's application stated that "I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses I hold." Licensee signed and acknowledged this statement. (Exhibit 1.)
- b. In a Letter of Qualification sent to Licensee, Licensee was told, "You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions." (emphasis in original). Licensee received this notice in her Letter of Qualification. (Exhibit 2.)
- c. After she had been granted an Active license, a search of the KHCSF showed Licensee was not in compliance with the Kansas Healthcare Stabilization Fund ("KHCSF").
- d. On September 16, 2019, and October 18, 2019, the Board requested Licensee to provide proof of compliance with the KHCSF, as required by K.S.A. 40-3404. The Board included instructions on how to contact KHCSF and warned that a failure to provide proof of compliance may result in a fine or suspension of Licensee's license to practice medicine in Kansas. (Exhibit 3 and 4.)

- e. On or about November 8, 2019, after receiving no response to the September 16, 2019, and October 18, 2019, letters, the matter was referred to the Litigation Department.
- f. On or about July 28, 2020, a subsequent search showed that Licensee had become compliant with the Fund on June 9, 2019. This compliance expired June 9, 2020.
- g. Licensee was previously out of compliance with the KHCSF since on or about March 12, 2019, until at least June 9, 2019, and then again from June 9, 2020, until at least July 28, 2020, while holding an Active license to practice medicine and surgery in Kansas. (Exhibit 5.)
- h. Licensee provided a Certificate of Compliance to show that she is now in compliance with the KHCSF from March 11, 2020 to March 11, 2021. (Exhibit 6.)

Applicable Law

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

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

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

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

(b) A nonresident health care provider shall not be licensed to actively render

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

(1) Every insurance company authorized to transact business in this state, that is authorized to issue professional liability insurance in any jurisdiction, shall file with the commissioner, as a condition of its continued transaction of business within this state, a form prescribed by the commissioner declaring that its professional liability insurance policies, wherever issued, shall be deemed to provide at least the insurance required by this subsection when the insured is rendering professional services as a nonresident health care provider in this state. Any nonadmitted insurer may file such a form.

(2) Every nonresident health care provider who is required to maintain basic coverage pursuant to this subsection shall pay the surcharge levied by the board of governors pursuant to subsection (a) of K.S.A. 40-3404 and amendments thereto directly to the board of governors and shall furnish to the board of governors the information required in subsection (a)(1). . .

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

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

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

self-insurer, the premium surcharge shall be paid upon submitting documentation of compliance with K.S.A. 40-3402, and amendments thereto.

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

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

Conclusions of Law

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

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

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

IT IS HEREBY ORDERED that Licensee is assessed a **CIVIL FINE** in the amount of five-hundred dollars (**\$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 Amended Summary Order shall be mailed to the Board certified and addressed to:

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

PLEASE TAKE NOTICE that upon becoming effective as a Final Order, this document shall be deemed a public record and be reported to any reporting entities authorized to receive such disclosure.

Dated this 27th day of August 2020.

**KANSAS STATE BOARD
OF HEALING ARTS**



Tucker L. Poling
Acting Executive Director

FINAL ORDER NOTICE OF RIGHTS

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

CERTIFICATE OF SERVICE

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

Angie R. Taras, M.D.
CONFIDENTIAL

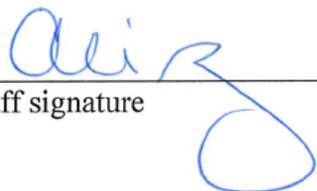
Licensee

And a copy was hand-delivered to:

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

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

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



Staff signature

QUALIFICATIONS APPLICATION

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

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

_____ WISCONSIN _____

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

3. What is the license number issued to you by the SPL board? 55873-20

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

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

If yes, provide the following:

Residence Street address **CONFIDENTIAL** _____

Residence City State Zip _____
City St Zip

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

If yes, describe your current practice _____

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

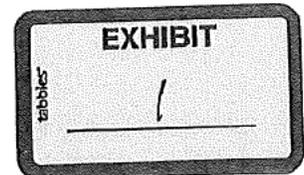
If Yes, Employer name _____

Employer street address _____

Employer City State Zip _____
City St Zip

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

If yes, give Tax ID # (SS#, EIN) **CONFIDENTIAL** _____ (must be most recent return)



5. Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes No

6. Have you passed each component of the United State Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes(if in question contact your SPL)? Yes No

7. Have you successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association? Yes No

8. Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? Yes No

9. Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? Yes No

10. Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? Yes No

11. Have you ever had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? Yes No

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

Physician's Signature: Angie Rosanne Taras
Type Name: Angie Rosanne Taras

Date: 11/13/2017 | 6:07 CST

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

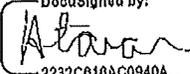
I, ANGIE TARAS (Type in full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect, that I hold a current and valid IMLC Letter of Qualification ("LOQ") Issued on (Date) 2/15/18 by (SPL) WISCONSIN as my State of Principal License, and that I continue to meet all requirements to qualify for the LOQ.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as my being prosecuted under appropriate federal and state laws.

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

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

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

Physicians Signature  _____
DocuSigned by:
2232C610AC0940A...

Type Physician's Name ANGIE TARAS

Applicant's NPI 1841410479

DATE 2/13/2019 | 1:11 CST

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

Thank you for applying through the Interstate Medical Licensure Compact.

All fees are non-refundable

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

I, Angie Rosanne Taras (Type in full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as my being prosecuted under appropriate federal and state laws.

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

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

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

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

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

DocuSigned by:
Applicant Signature Angie Rosanne Taras

2232C016AC0940A...
Type Applicant's Name Angie Rosanne Taras

Applicant's NPI 1841410479

DATE 11/13/2017 | 6:07 CST

In Process

PHYSICIAN'S CORE DATA SHEET

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

Full Legal Name Angie, Rosanne, Taras
First Middle Last Suffix(Sr., Jr.)

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

Mailing address of public record _____
Mailing address City State(XX) Zip

CONFIDENTIAL

Office address 2350 Ravine Way, Suite 400, Glenview, IL, 60025
Office address City State(XX) Zip

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

Physician's office or practice telephone number of public record 312-715-7552
(###-###-####)

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

Physician's Email Address to receive correspondence CONFIDENTIAL

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

Physician's National Provider Identifier Number 1841410479

Medical Degree Received: M.D. D.O.

(Medical school must be accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or be listed in the International Medical Education Directory or its equivalent.)

Medical School Medical College of Wisconsin
Name of School (no abbreviations or acronyms)
Date of Degree Issued 05/20/2005
(mm/dd/yyyy)

Physicians must have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. (NOTE: One-year transitional residencies do not meet this requirement)

Residency Program Swedish Medical Center Completion Date 06/30/2011
Full Program Name (no abbreviations or acronyms) (mm/dd/yyyy)

What is the specialty of the program General surgery

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

Number of attempts taken to pass the USMLE:

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

Number of attempts taken to pass the COMLEX:

Step 1: _____ Step 2 PE: _____ Step 2 CE: _____ Step 3: _____

Number of attempts taken to pass other licensing exam:

Step 1: _____ Step 2: _____ Step 3: _____

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

Specialty Board Certification: American Board of Surgery
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

Lifetime: **IN PROCESS**
Time limited: Expiration date of time limited 07/01/2023
(mm/dd/yyyy)

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

License # 55873-20 Date of Original Licensure 06/13/2011 (not renewal)
(mm/dd/yyyy)

Expiration Date 10/31/2019 Status of License: Current: Not Current:
(mm/dd/yyyy)

Thank you for applying through the Interstate Medical Licensure Compact.

*The state will contact you to give instructions on obtaining your fingerprints for a criminal background check. **YOU HAVE 60 DAYS TO COMPLY WITH REQUESTS FROM THE STATE** to avoid automatic withdraw. Background checks may take some time, so please be patient. If you have any concerns contact your SPL. SPL contact numbers can be found at www.IMLCC.org. You will receive an email regarding the status of your qualification. Be sure to check your spam folder and set your email to accept messages from the @docusign.net and @docusign.com domains.*

FOR USE OF STATE OF PRINCIPAL LICENSE

I have conducted the verification process of this physician's application.

State Authorized Signature _____

DocuSigned by:

Justin Taylor

3D878EF09Z174ED...

Type Name Justin Taylor

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

Title LPPA

CORE DATA CORRECTION SHEET

To process corrections please use the below freeform text boxes. The corrections will be passed to the Member Boards selected to issue licenses. If you use this sheet there is no need to send any correction emails.

Core Data to be changed	Incorrect data	Correction
specialty Expiration Date	07/01/2023	12/31/2023
none	none	none

In Process

Letter of Qualification Verification

A review of records of the (Board) Wisconsin Medical Examining Board
indicates that (Physician Name) Angie Rosanne Taras
holds a Letter of Qualification for licensure in Member States of the Interstate
Medical Licensure Compact. The Letter of Qualification was issued on (Issue
Date) 2/15/2018 and will be valid for 365 days from that date.

(Board) IMLCC

In Progress



DocuSigned by:
Marshall S. Smith
382E3B0AC253486
Signature

Marshall S. Smith

Type Name

Executive Director

Title

2/13/2019 | 5:21 CST

Date

Letter of Qualification

Date 02/15/2018
mm/dd/yyyy

Name: Angie Rosanne Taras

Address: **CONFIDENTIAL**

CityStZip _____

Dear Dr. Taras:

RE: Your application for IMLC Letter of Qualification

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

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

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

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

Authorized Signature from SPL _____
DocuSigned by:
Justin Taylor

Type Name Justin Taylor
3D670EF097174ED...

Title of Authorized SPL LPPA

DATE 2/15/2018 | 12:52 CST

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Angie Rosanne Taras
First Name Middle Name Last Name

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

National Provider Identifier Number 1841410479

Medical Board Name Minnesota Board of Medical Practice

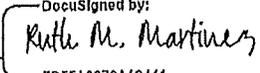
Member Board License Number 63670

Date License Issued 04/26/2018
mm/dd/yyyy

Date of Expiration 10/31/2018
mm/dd/yyyy

In Process

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

Member Board Signature 
DocuSigned by:
Ruth M. Martinez
7D55A0270A19441...

Type Name Ruth M. Martinez

DATE 4/26/2018 | 2:11 CDT



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
10/03/2018

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Poms & Associates Insurance Brokers 320 Osuna Road N.E. Suite C-1 Albuquerque NM 87107	CONTACT NAME: Carol Johnson	FAX (A/C, No): (505) 797-1432
	PHONE (A/C, No, Ext): (800) 898-6236	E-MAIL ADDRESS: CJohnson@PomsAssoc.com
INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A: Mt. Hawley Insurance Company		37974
INSURER B:		
INSURER C:		
INSURER D:		
INSURER E:		
INSURER F:		

COVERAGES CERTIFICATE NUMBER: 18-19 MPL REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE	\$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
							MED EXP (Any one person)	\$
							PERSONAL & ADV INJURY	\$
							GENERAL AGGREGATE	\$
							PRODUCTS - COMP/OP AGG	\$
								\$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident)	\$
							BODILY INJURY (Per person)	\$
							BODILY INJURY (Per accident)	\$
							PROPERTY DAMAGE (Per accident)	\$
								\$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE	\$
							AGGREGATE	\$
								\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A				PER STATUTE	OTH-ER
							E.L. EACH ACCIDENT	\$
							E.L. DISEASE - EA EMPLOYEE	\$
							E.L. DISEASE - POLICY LIMIT	\$
A	MEDICAL PROFESSIONAL LIABILITY			CONFIDENTIAL	05/13/2018	05/13/2019	PER LOSS EVENT	\$1,000,000
							POLICY AGGREGATE	\$4,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

PHYSICIAN: Angie Rosanne Taras, MD, FACS

RETROACTIVE DATE: 10/02/2018

*VIRGINIA LIMITS: \$2,150,000 PER LOSS EVENT/\$6,450,000 AGGREGATE

*NEW YORK LIMITS: \$1,300,000 PER LOSS EVENT/\$3,900,000 AGGREGATE

CERTIFICATE HOLDER NET MEDICAL XPRESS SOLUTIONS, INC. TELERAD SERVICE, INC. 5021 INDIAN SCHOOL ROAD NE SUITE 100 ALBUQUERQUE NM 87110	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE

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CERTIFICATE OF INSURANCE

DR ANGIE ROSANNE TARAS
CONFIDENTIAL

Membership No: SM69931

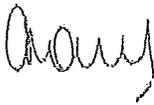
Policy No: **CONFIDENTIAL**

Insured Doctor:	DR ANGIE ROSANNE TARAS	
Insurer:	Medical Insurance Australia Pty Ltd	
Category:	Cosmetic Surgery Level D	
State(s) of Practice:	VIC	100.00%
Type of Insurance:	Medical Indemnity Insurance	
Period of Insurance:	1 July 2018 to 30 June 2019	
Retroactive Date:	15 June 2015	
Claims and Expenses that We cover You for:	Claims and Claim Costs: Expenses:	Included Included
Aggregate Limit of Cover and Sub-Limits of Cover:	Aggregate Limit of Cover for Claims, Claims Costs and Expenses: \$20,000,000 Aggregate Limit of Cover for Expenses: \$1,500,000	
	Note: Sub-Limits of Cover apply and they are detailed in your Quotation and Policy Schedule.	
Deductible:	- \$1,000 any one claim, Inclusive of Expenses for cover under clauses 1.4(b) and 1.4(c) "Other complaints and disputes" - \$5,000 any one claim, Inclusive of Expenses for cover under clause 2.19 "Protection of reputation" - Nil for all other cover under the Policy	

Other matters that We cover You for, where listed as Included

Good Samaritan Acts and Gratuitous Advice:	Included
Vicarious liability:	Included
Practice outside the Commonwealth of Australia*:	Included
Volunteer Practice:	Included
Liability for restricting ability to practise:	Included
Medical research and clinical trials:	Included
Loss of Documents:	Included
Advice and advisory assistance:	Included
Severability and non-imputation:	Included
Continuous cover:	Included
ROCS prescribed events:	Included
ROCS Gap cover:	Included
Interruption to income and out of pocket expenses cover:	Included
Run-off cover:	Included
Public Patients:	Included
Liability for complaints about others:	Included
Innocent partner cover:	Included
Protection of reputation:	Included
Pursuit of indemnity:	Included
Public relations Expenses:	Included
Unintentional intellectual property rights Infringements:	Included
Communicable disease cover:	Included
Prior practice:	Included
Statutory liability:	Included
Mandatory breach notification:	Included

(*Incorporates accompanying an Australian sporting team or Australian cultural group cover worldwide)



Carolyn Norris
National Manager - Client Services

Date: 25 July, 2018

Important Notice: This certificate is issued for information purposes only and does not confer any rights upon the holder. This certificate is issued as a summary and does not amend, extend or alter the Policy of Insurance. For full particulars, reference must be made to the current Medical Indemnity Insurance Policy and Schedule. The details contained in this certificate are current at the date of issue.

(c.curr_mia2019)

Letter of Qualification

Date 02/15/2018
mm/dd/yyyy

Name: Angie Rosanne Taras
CONFIDENTIAL

Address:

CityStZip _____

Dear Dr. Taras:

RE: Your application for IMLC Letter of Qualification

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

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

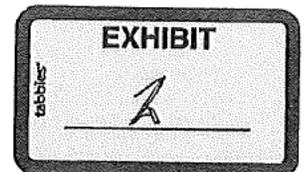
An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license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

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

Authorized Signature from SPL _____
DocuSigned by: Justin Taylor
Type Name Justin Taylor

Title of Authorized SPL LPPA

DATE 2/15/2018 | 12:52 CST



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

1425768

Angie Rosanne Taras, MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; 04-41958

Dear Dr. Taras:

Under the Kansas State Board of Healing Arts ("Board") audit process, you have been selected to provide proof of your professional liability insurance and Kansas Health Care Stabilization Fund ("KHCSF") compliance for your most recent renewal period.

In Kansas, if you have an Active license, you are required to maintain professional liability insurance of not less than \$200,000 per claim, and not less than \$600,000 annual aggregate for all claims made during the policy period. *See* K.S.A. 40-3402(a)-(b); K.S.A. 65-2809(c). Additionally, you are required to maintain compliance with the KHCSF by paying the annual surcharge. *See* K.S.A. 40-3402; K.S.A. 40-3404; and K.S.A. 65-2809(c).

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

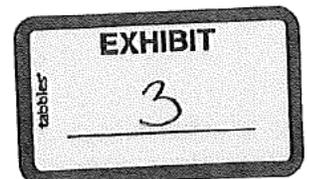
Please provide proof of your: (1) professional liability insurance; and (2) KHCSF compliance for the period for which you renewed your license, on or before **October 16, 2019**. Failure to produce this requested information may result in disciplinary action against your license, including but not limited to, a fine, a public censure, and/or **SUSPENSION** of your license. Submit all proof via email to KSBHA_Licensing@ks.gov.

To effectuate submission of evidence of KHCSF compliance to the Board, you must contact the KHCSF and obtain a certification that you have paid the annual premium charges. You must then submit a copy of the certification to the Board. Please keep in mind, if you are a non-resident, you must also submit a non-resident form to the KHCSF.

If you have questions about submitting forms to or compliance with the KHCSF, you can contact the 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, ATOHISON • MARK BALDERSTON, DC, SHAWNEE
R. JERRY DEGRADO, DC, WICHITA • ROBIN D. DURRETT, DO, GREAT BEND • THOMAS ESTEP, MD, WICHITA • ANNE HODGDON, PUBLIC MEMBER, LENEXA
JOEL R. HUTCHINS, MD, HOLTON • STEVE KELLY, PUBLIC MEMBER, NEWTON • DAVID LAHA, DPM, OVERLAND PARK • DOUGLAS J. MILFELD, MD, WICHITA
GAROLD O. MINNS, MD, BEL AIRE • KIMBERLY J. TEMPLETON, MD, LEAWOOD • RONALD M. VARNER, DO, EL DORADO

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



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

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

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

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

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

Sincerely,

Rebekah Moon

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

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

TTY (HEARING IMPAIRED) 711 OR 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

1425768
Angie Rosanne Taras, MD
CONFIDENTIAL

RE: Professional Liability Insurance & Kansas Health Care Stabilization Fund Audit; Final Notice; 04-41958

Dear Dr. Angie Rosanne Taras:

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.

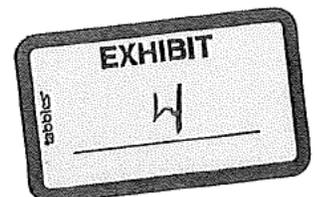
If you are unable to provide a Certificate of Compliance from HCSF, please contact HCSF through the contact information described below. Please remember, once you have obtained your Certificate of Compliance from HCSF, you must then submit a copy of the certification to the Board. Additionally, if you 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
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R. Jerry DeGrado, DC
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Anne Hodgdon, Public Member
Lenexa
David Leha, DPM
Overland Park
Kimberly J. Templeton, MD
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John F. Seilich, Ph.D., Public Member, Vice President
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Holton
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Ronald M. Varner, DO
Augusta

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

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

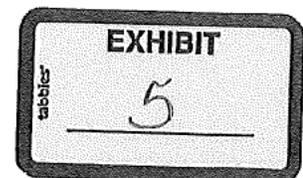
HCP Name	ID No.	Agency	License	Res.	Status	Retro Date	Address
TARAS ANGIE	MD 119131	110	04-41958	N	A	06/09/2019	CONFIDENTIAL

Company	Policy	Rate	Level	Fund Type	Effective	Expiration	Surcharge	Document reference numbers
RLI INSURANCE COMPANY	CONFIDENTIAL A1	2102	1		06/09/2019	06/09/2020	\$ 100.00	

[Search Again](#) | [Return to HCSF Website](#)

Feedback

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





Health Care Stabilization Fund

300 S.W. 8th Avenue, Second Floor
Topeka, Kansas 66603-3912

hcsf@ks.gov
785-291-3777

CERTIFICATION OF COMPLIANCE

PROVIDER INFORMATION

Name TARAS, ANGIE R
Title MD **KS License** 04-41958

HCSF Level \$100,000/\$300,000

POLICY INFORMATION

Insurance Co. NATIONAL FIRE & MARINE INS CO.

Policy **CONFIDENTIAL**

Type Claims made basic coverage

Effective Date 3/11/2020

Expiration 3/11/2021

Confirmed By Gwen Saiya
Title Compliance Officer
E-Mail gwen.saiya@ks.gov
Dated 8/24/2020

