Arizona State Board of Medical Examiners
P.O. Box 6200, Scottsdale, Arizona 85261 -6200
Home Page: http://www.bomex.org
Telephone (480) 551-2700 • Fax (480) 5512704 • In-State Toll Free (877) 255-2212

APPLICATION for LICENSE to PRACTICE ALLOPATHIC MEDICINE in the STATE of ARIZONA
and INITIAL REGISTRATION FORM

A x 3" ph y of yo nly . Ph ıken wi l be sig ower po

Proof photos, negatives, Polaroid type photos are not acceptable.

FOR BOARD USE
DO NOT USE THIS SPACE

Date Application Sent: _____

Date Application Received: 12/05/00

☐ ENDORSEMENT
☐ USMLE
☐ SPEX

#12006

ALL FORMS PROVIDED MUST BE COMPLETED BY THE APPROPRIATE AGENCY AND RETURNED DIRECTLY TO THIS BOARD

INFORMATION

All candidates shall provide satisfactory evidence that he/she:

1. Possesses a good moral and professional reputation.
2. Is physically and mentally able to engage safely in the practice of medi cine.
3. Has not been found guilty of any act of unprofessional conduct; medical incompetence; or mentally or physically unable to engage safely in the practice of medicine.
4. Has not had disciplinary action taken against him by any other state, territory, dist rict or country for reasons relating to his ability to engage safely and skillfully in the practice of medicine.

NOTE: The processing of a routine application can take 8 to 10 weeks. Applications not fully complete within one year from date of notification of deficiency in application are considered withdrawn.

APPLICATION INSTRUCTIONS
(Read Carefully)

In addition to the appropriate completion of the applicable sections of this application, the applicant will submit the following:

1. Evidence of name and date of birth: a certified copy of birth certificate or other documentary evidence for consideration i.e., Visa, Passport; baptismal certificate, alien resident card, or naturalization certificate.
2. Certified evidence of any legal name changes other than tha t shown on certificates filed in accordance with paragraph 1 above, (e.g., marriage certificate). Proof of foreign birth of American parents.
3. A complete list of all your hospital affiliations and employment for the five years prior to filing this applicat ion.
4. **Cashier' s Check or Money Order in U.S. Funds**(personal checks not accepted) , covering the statutory fee prescribed in statute and rule.
5. Credentials submitted in foreign languages shall have affixed thereto a certified translation into English.
6. Separated or mutilated Applications are not acceptable and will require refiling.
7. Requests for exemptions or waivers of any portion of this application will be denied and will delay your consideration for licensure.
8. **NOTE:** All credentials submitted become the pr operty of the Arizona Board of Medical Examiners and **NONE** will be returned. **DO NOT SUBMIT ORIGINALS.**
9. **Photocopies shall not exceed 8 ½ inches by 11 inches in size.**

UNITED STATES OR CANADIAN MEDICAL SCHOOL GRADUATES and GRADUATES OF MEDICAL SCHOOLS LOCATED OUTSIDE THE UNITED STATES OR CANADA will forward Forms numbered I, II, III, III[redacted] and IV as may be applicable, to the appropriate agency[redacted] the request that they be completed and returned to the Arizona Board of Medical Examiners.

APPLICATION and Initial Registration

(To be completed, signed by applicant and notarized. All questions MUST be answered completely.)

1. Present Legal Name AUERBACH (Last) SAMUEL (First) LOUIS (Middle) _____ (Maiden)

   (a) Other names used: —

2. Office Address: 18615 Burbank Blvd (No.) (Street) Tarzana (City) CA (State) 91356 (Zip Code) 818-609-9070 (Phone)

3. City and State of Birth [redacted] Month, Day and Year of Birth [redacted]

4. In what states or provinces have you applied for or been granted license or registration? If more than two, attach separate listing. If license not issued, so state.

   (a) New York (State Board) _____ (Date of Application) _____ (Result) 191774 (Certificate No.)

   _____ (Date Issued) _____ (Specify if by Written Examination or on Credentials)

   (b) California (State Board) _____ (Date of Application) _____ (Result) A053310 (Certificate No.)

   _____ (Date Issued) _____ (Specify if by Written Examination or on Credentials)

5. Have you ever had an application or medical license denied or rejected by another state/province licensing board? NO (Answer)
6. Has any disciplinary or rehabilitative action ever been taken against you by any state licensing board, including other health professions? Examples of actions include but are not limited to reprimand, censure, probation, restriction, limitation, suspension, stipulation, written consent agreement or revocation. NO (Answer)
7. Have any disciplinary actions, restrictions, limitations ever been taken against you while you were participating in any type of training program or by any health care provider? NO (Answer)
8. Have you ever been found to be in violation of any statute, rule or regulation of any domestic or foreign governmental agency? NO (Answer)
9. Has there been any disciplinary action initiated against you by or through any medical board or association? NO (Answer)
10. Are you currently under investigation by any medical board or peer review body? NO (Answer)
11. Have you ever had a medical license disciplined resulting in a: revocation, suspension, limitation, restriction, probation, voluntarily surrender, cancellation during an investigation or entered into a consent agreement or stipulation? NO (Answer)
12. Have you ever had hospital privileges revoked, denied, suspended or restricted in any way? NO (Answer)
13. Have you ever been named as a defendant in any malpractice matter currently pending or which resulted in a settlement or judgement against you? NO (Answer)
14. Have you ever been convicted of insurance fraud or received sanctions, including restriction, suspension or removal from practice, imposed by any agency of the federal government? NO (Answer)
15. Have you ever had your ability to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered or revoked by a federal or state agency? NO (Answer)

16. Are your currently in engaged in the illegal use of any controlled substance, habit forming drug or prescription medication? [redacted]

17. Have you consumed intoxicating beverages resulting in your present ability to exercise the judgement and skills of a medical professional being impaired or limited? [redacted]
(Answer)

18. Have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? NO
(Answer)

Note: **In the event the response to any of the questions numbered 5 through 18 is YES, the applicant will file with the application a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such charge(s). Provide the name and address of applicant's insurance carrier. IN ADDITION, the applicant must submit photocopy(ies) of any complaints, hearings, settlements or judgements together with copies of patient's hospital and/or office records to this board.**

19. Do you have or have you had within the last five years any medical condition that in any way impairs or limits your ability to safely practice any field of medicine? [redacted]
(Answer)

Ability to practice medicine is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as a voice amplifier; and

3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotion or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug-addiction and alcoholism.

20. Within the last five years, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted]
(Answer)

In the event the response to question 19 and/or 20 is yes, you must file with the application a detailed written narrative statement concerning the above matter(s), including the name and address of the training program or health care provider, physician, preceptor, hospital/rehabilitation, etc. where you were counseled/treated. You must provide a certified copy of your history and physical examination, consultation report(s), discharge summary(ies) from the hospital/rehabilitation center, and a statement from your attending physician(s) or treating therapist setting forth your diagnosis, prognosis and recommendations for continuing care, treatment and supervision.

21. Name and location of Medical School: UNIVERSIDAD DEL NORESTE
Tampico Tamps MEXICO

22. List Internship, Residency and Fellowship training **(COMPLETED OR NOT),** OR, Assistant Professorship (or higher) at approved school of medicine chronologically showing institution, address, type of program and dates. Attach separate listing if needed.

SEE ATTACHED SHEET #1

23. Are you certified by any of the American Board of Medical Specialties? NO

24. Exact whereabouts and nature of practice or other activities from the date of graduation from medical school to the present, with specific MONTH AND YEAR listed for each. NO PERIOD UNACCOUNTED FOR IS ALLOWED.

At _____ from _____ to _____
(City) (State)

At ATTACHED from _____ to _____
(City) SHEET (State)

At #2 from _____ to _____
(City) (State)

At (TO FOLLOW) from _____ to _____
(City) (State)

The applicant SAMUEL LOUIS AUERBACH

(PRINT OR TYPE YOUR NAME AS YOU WISH IT TO APPEAR ON YOUR MEDICAL LICENSE)

being first duly sworn upon his oath deposes and says: that he is the person herein named subscribing to this application; that he has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he is the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Arizona Board of Medical Examiners or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Arizona Board of Medical Examiners or its successors to release to the organizations, individuals or groups listed above any information which is material to the application or any subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

SHERYL S. BACA
Commission # 1194978
Notary Public - California
Los Angeles County
My Comm. Expires Aug 30, 2002

(NOTARY SEAL)

Signature of Applicant Samuel Louis Auerbach, M.D.

STATE OF California

County of Los Angeles

Subscribed and sworn to before me this 1st day of December 2000

Notary Signature Sheryl S. Baca (NOTARY PUBLIC) My Comission expires Aug 30, 2002

FOR OFFICIAL USE ONLY

Application Processed by ma 1/9/01

Application Checked by

Application Approved 19 12/3/01 By Gordon L. Odom, Exec Mgr

License Issued 12/14/01

License Number 29924

(THIS FORM MAY BE COPIED IF ADDITIONAL COPIES ARE NEEDED)

ARIZONA STATE BOARD OF MEDICAL EXAMINERS

HOSPITAL AFFILIATIONS/MEDICAL EMPLOYMENT

INSTRUCTIONS: 1) List all hospital affiliations for the past five (5) years to include moonlighting and Courtesy staff affiliations. Do not include any postgraduate training.
2) List all medical employment e.g. physician placement group, emergency medical group, radiology group, etc.

APPLICANT NAME: SAMUEL LOUIS AUERBACH MD

1. HOSPITAL: PRIVATE PRACTICE

   ADDRESS: 18615 BURBANK BLVD - SUITE #214; TARZANA CA 91356
   City State Zip Code

   DATES OF STAFF MEMBERSHIP: _____

   TYPE/CATEGORY OF STAFF MEMBERSHIP: _____

2. HOSPITAL: _____

   ADDRESS: _____
   City State Zip Code

   DATES OF STAFF MEMBERSHIP: _____

   TYPE/CATEGORY OF STAFF MEMBERSHIP: _____

3. HOSPITAL: _____

   ADDRESS: _____
   City State Zip Code

   DATES OF STAFF MEMBERSHIP: _____

   TYPE/CATEGORY OF STAFF MEMBERSHIP: _____

4. MEDICAL EMPLOYMENT: _____

   ADDRESS: _____
   City State Zip Code

   DATES OF EMPLOYMENT: _____

5. MEDICAL EMPLOYMENT: _____

   ADDRESS: _____
   City State Zip Code

   DATES OF EMPLOYMENT: _____

POST-GRADUATE MEDICAL TRAINING

9/19/94 - 9/18/95	Preceptorship (Fellowship), Breast Disease Melvin Silverstien, M.D., Medical Director/ Van Nuys, California
7/1/93 - 6/30/94	Fellowship. Advanced Pelvic, Gynecologic & Oncologic Surgery S.U.N.Y. at Buffalo, Hospital Corsortium
7/89 - 9/91	Resident, Obstetrics & Gyencology University of Southern Alabama Medical Center Mobile, Alabama
8/88 - 6/89	Resident, Obstetrics & Gynecology Lutheran Medical Center Brooklyn, New York
7/87 - 6/88	Resident, Obstetrics &Gynecology Albany Medical Center Albany, New York
7/86 - 6/87	Resident, Obstetrics & Gynecology S.U.N.Y. at Syracuse, New York Johnson City, New York
7/85 - 6/86	Resident, Internal Medicine Mount Sinai Hospital Bronx VA Medical Center New York, New York
7/84 - 6/85	Resident, Internal Medicine Millard Fillmore Hospital Buffalo, New York

MEDICAL EDUCATION

7/83 - 6/84	Fifth Pathway Program S.U.N.Y. - Buffalo
8/76 - 6/80	Universidad Del Noreste Tampico, Mexico M.D. Degree

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.bomex.org

Form 2
Medical College Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the medical school granting the medical degree. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECT to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258. Your prompt response will be appreciated.

Name: SAMUEL LOUIS AUERBACH, M.D.

Samuel Louis Auerbach 8-21-01
Signature Samuel Louis Auerbach 10/15/01 Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by an officer of the medical school.

This is to certify that SAMUEL LOUIS AUERBACH
(Full name of student)

was granted the degree of DIPLOMA DE MEDICO CIRUJANO Y PARTERO

by UNIVERSIDAD DEL NORESTE A.C on Junio/06/1980
(Full name of School or College of Medicine as it appears on the Applicant's Medical degree diploma.) Date (Month/Day/Year)

that the date of his/her matriculation in medical school was Agosto 16 de 1976, and that he/she attended ____ (number) full courses of medical lectures comprising ____ (number) months.

1. Was applicant ever placed on probation, restricted, or limited? NO If yes, please attach written explanation.
2. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

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3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation.
4. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes XX No ____ If no please attach written explanation.

Signed: LIC. MARIO A. LIZARRAGA B., MD. (Seal of College)

Dean / President / Secretary / Registrar of SERVICIOS ESCOLARES Date: OCTUBRE, 24, 2001
(Month/Day)

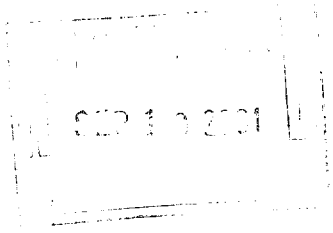
Address: PROL. AV. HGO.6315 COL. NUEVO AEROPUERTO, TAMPICO TAMAULIPAS, MEXICO

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

PHILADELPHIA OFFICE
3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A.
TELEPHONE: 215-386-5900 • FAX: 215-386-3185 • INTERNET: www.ecfmg.org

State Board Code:
003
Please include this number on all requests

Executive Director
Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258



ECFMG CERTIFICATION STATUS REPORT

ECFMG/USMLE Identification Number: 0-312-430-2
Applicant's Name: Samuel Louis Auerbach
Applicant's Date of Birth: [redacted]
ECFMG Certified: No

Certificate Issued Date: N/A
English Test Valid Through Date: N/A
Clinical Skills Assessment Valid Through Date: N/A

Passing Performance on Medical Science Examination for Certification:

Examination Type	Date	Component	Two-Digit Score	Three-Digit Score	Comments
ECFMG 1-DAY	01/26/1983	MEDICAL SCIENCE	75		

Most Current Passing Performance on Clinical Assessment for Certification: N/A

Most Current Passing Performance on English Test: JANUARY 1983

Name of Medical School and Country:

Degree Year:

† Medical Education Credential Status: Incomplete

This information is reported directly from ECFMG computer records and is current as of 09/07/2001.

* The purpose of this Status Report is to indicate whether this individual is ECFMG certified. This status report is not a complete history of all examinations this individual may have taken. It reflects only passing scores on the examination(s) used to fulfill the Medical Science Examination requirement for ECFMG certification. It aslo includes the most current passing performance on the Clinical Skills Assessment (CSA), regardless of whether CSA was required for ECFMG certification.

† Since July 1986, ECFMG has verifed medical school credentials directly with the medical schools or through a reasonable alternative which has been approved by the ECFMG Medical Education Credentials Committee.

Important Note:
Requesting organizations must secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization.

ECFMG is an organization committed to promoting excellence in international medical education.

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.bomex.org

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Form 3
Postgraduate Training Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECT to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258. Your prompt response will be appreciated.

Name: SAMUEL AUERBACH MD, M.D.

Samuel Auerbach MD — 6-15-01
Signature — Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved postgraduate training in the United States or Canada.

This is to certify that SAMUEL AUERBACH, M.D. undertook and satisfactorily completed a full term approved program of 10 (number) months in the FIFTH PATHWAY PROGRAM (Full name and complete address of hospital)

in the field of MEDICINE from 8-13-83 (Date) (Mo/Day/Yr) to 5-22-84 (Date/Anticipated Date)

and that the said program was approved for ~~postgraduate training~~ FIFTH PATHWAY during that period by the ~~Accreditation Council for Graduate Medical Education~~, or the Royal College of Physicians and Surgeons of Canada. Yes ✓ No _____ LCME

1. Was applicant ever placed on probation, restricted, or limited? NO If yes, please attach written explanation
2. Was there any reason not to continue applicant in the training program? Yes _____ No NO
3. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation.
4. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes YES No _____ If no please attach written explanation.

Signed: _____, M.D. (Seal of Hospital)

Title: ASSOC. DEAN

Address: 40 BEB
BUFFALO, NY 14214

Date: 10-18-01

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.bomex.org

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By

Form 3
Postgraduate Training Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECT to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258. Your prompt response will be appreciated.

Name: SAMUEL AUERBACH MD, M.D.

Samuel Auerbach MD 6-15-01
Signature Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved postgraduate training in the United States or Canada.

This is to certify that Samuel Auerbach M.D. undertook and satisfactorily completed a full term approved program of 10 (number) months in the UNIVERSITY AT BUFFALO OFFICE OF MEDICAL EDUCATION School (Full name and complete address of Hospital) RM 40 BEB 3435 MAIN ST. BUFFALO, NY 14214

in the field of medicine from 8/15/83 (Date) (Mo/Day/Yr) to 5/20/84 (Date/Anticipated Date)

and that the said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. Yes ✓ No _____

1. Was applicant ever placed on probation, restricted, or limited? NO if yes, please attach written explanation
2. Was there any reason not to continue applicant in the training program? Yes _____ No ✓
3. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

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3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation.
4. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes ✓ No _____ If no please attach written explanation

Signed: _____, M.D. (Seal of Hospital) School

Title: Assoc. Dean Dennis Nolder

Address: UNIVERSITY AT BUFFALO OFFICE OF MEDICAL EDUCATION RM 40 BEB 3435 MAIN ST. BUFFALO, NY 14214

Date: 6/22/01

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.bomex.org

Form 3
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Name: SAMUEL AUERBACH MD, M.D.

Samuel Auerbach MD 6-15-01
Signature Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved postgraduate training in the United States or Canada.

This is to certify that Samuel L. Auerbach, M.D. undertook and satisfactorily completed a full term approved program of 12 (number) months in the Millard Fillmore Hosp. (Full name and complete address of Hospital) 3 Gates Circle Buffalo, NY 14209 in the field of Internal Medicine from 7/1/84 (Date) (Mo/Day/Yr) to 6/30/85 (Date/Anticipated Date)

and that the said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. Yes ✓ No _____

1. Was applicant ever placed on probation, restricted, or limited? NO If yes, please attach written explanation
2. Was there any reason not to continue applicant in the training program? Yes _____ No ✓
3. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

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3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation.
4. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes ✓ No _____ If no please attach written explanation.

Signed: Marie A. Bailey ~~M.D.~~ (Seal of Hospital)

Title: Dir/Medical Staff & Educ

Address: MFH/3 Gates Circle/Bflo, NY 14209 Date: 10/23/01

(2)

These programs are no longer functioning
Information Taken from hospital records

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
130 West Kingsbridge Road
Bronx, New York 10468

July 4, 2001

In Reply Refer To: 526 (00ED/IM)

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

SUBJ: Residency Verification

Dear Sir or Madam:

The verification of the resident/fellow in question is complete. After a complete review of this individuals personnel records for the time period requested, I can verify that this individual completed the training for such time in the correct subspecialty, at the Bronx VAMC. If you have any questions or comments, please feel free to contact me at (718) 584-9000/x6906.

RE: Samuel L. Auerbach, M.D.

SS#: [redacted]

PERIOD: 71/85 ⟶ 6/30/86

PROGRAM: Medical Service/Internal Medicine

Sincerely,

David Jaipersaud
Clinical Programs Coordinator

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.bomex.org

Form 3
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Name: SAMUEL AUERBACH MD, M.D.

Samuel Auerbach MD 6-15-01
Signature Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved postgraduate training in the United States or Canada.

This is to certify that _____, M.D. undertook and satisfactorily completed a full term approved program of _____ (number) months in the _____ (Full name and complete address of Hospital)

_____

in the field of _____ from _____ (Date) (Mo/Day/Yr) to _____ (Date/Anticipated Date)

and that the said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. Yes _____ No _____

1. Was applicant ever placed on probation, restricted, or limited? _____ If yes, please attach written explanation
2. Was there any reason not to continue applicant in the training program? Yes_____ No _____
3. Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? Yes_____ No _____

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

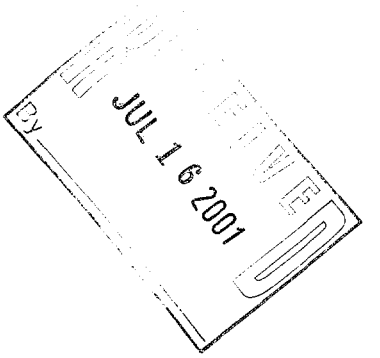
"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? Yes_____ No _____ If yes, please attach written explanation.
4. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes_____ No _____ If no please attach written explanation.

Signed: _____, M.D. (Seal of Hospital)

Title: _____

Address: _____ Date: _____



July 11, 2001

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona, 85258

RE: Samuel Auerbach, MD

United
Health Services
Hospitals

This letter is to confirm that Samuel Auerbach, MD successfully completed the following program at United Health Services Hospitals:

Internal Medicine Residency
Dates: July 1, 1986 to June 30, 1987

If you have any further questions, do not hesitate to contact me at 607-763-6674.

Sincerely,

James Jewell, MD
Director Internal Medicine Residency

Wilson Memorial Regional
Medical Center
33-57 Harrison Street
Johnson City, New York 13790
607.763.6000

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.bomex.org

RECEIVED
JUN 28 2001
By

Form 3
Postgraduate Training Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECT to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258. Your prompt response will be appreciated.

Name: SAMUEL AUERBACH MD, M.D.

Samuel Auerbach MD 6-15-01
Signature Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved postgraduate training in the United States or Canada.

This is to certify that SAMUEL AUERBACH, M.D undertook and satisfactorily completed a full term approved program of 12 (number) months in the ALBANY MEDICAL CENTER (Full name and complete address of Hospital)
43 NEW SCOTLAND AVENUE, ALBANY, NY 12208
in the field of OB/GYN from 07/01/87 (Date) (Mo/Day/Yr) to 6/30/88 (Date/Anticipated Date)

and that the said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. Yes X No ____

1. Was applicant ever placed on probation, restricted, or limited? NO If yes, please attach written explanation
2. Was there any reason not to continue applicant in the training program? Yes____ No X
3. Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation.
4. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes X No ____ If no please attach written explanation.

Signed: Ian H. Slater M.D. (Seal of Hospital)
Title: Prof. Peds. Assoc. Dean
Address: 205 JAY
ALBANY, N.Y. 12210
Date: 6/21/01

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.bomex.org

Form B3
Postgraduate Training Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECT to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258. Your prompt response will be appreciated.

Name: SAMUEL AUERBACH MD, M.D.

Samuel Auerbach MD 6-15-01
Signature Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved postgraduate training in the United States or Canada.

This is to certify that Samuel L. Auerbach, MD, M.D. undertook and satisfactorily completed a full term approved program of 10 (number) months in the Lutheran Medical Center (Full name and complete address of Hospital)
150 55th Street, Brooklyn, New York, 11220

in the field of Obstetrics/Gynecology from 8/24/88 (Date) (Mo/Day/Yr) to 6/30/89 (Date/Anticipated Date)

and that the said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. Yes X No

1. Was applicant ever placed on probation, restricted, or limited? no If yes, please attach written explanation
2. Was there any reason not to continue applicant in the training program? Yes_____ No X
3. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation.
4. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes X No _____ If no please attach written explanation.

Signed: Donald M. Zarou, M.D. (Seal of Hospital)
Donald M. Zarou, MD
Title: Chairman of Ob/Gyn
Address: 150 55th Street, Brooklyn, Ny, 11220 Date: 6-25-01

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.bomex.org

Form 3
Postgraduate Training Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECT to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258. Your prompt response will be appreciated.

Name: SAMUEL AUERBACH MD, M.D.

Samuel Auerbach MD — 6-15-01
Signature — Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved postgraduate training in the United States or Canada.

This is to certify that Samuel L. Auerbach, M.D undertook and satisfactorily completed a full term approved program of 27 (number) months in the Dept. of OB/GYN, Univ. of South AL, 251 Cox St., Suite 100, Mobile, AL 36604 (Full name and complete address of Hospital)

in the field of OB/GYN from 7-1-89 (Date) (Mo/Day/Yr) to 9-30-91 (Date/Anticipated Date)

and that the said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. Yes ✓ No ____

1. Was applicant ever placed on probation, restricted, or limited? No If yes, please attach written explanation
2. Was there any reason not to continue applicant in the training program? Yes ____ No ✓
3. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation.
4. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes ✓ No ____ If no please attach written explanation

Signed: [signature], M.D. (Seal of Hospital)

Title: Residency Program Director

Address: 251 Cox St Ste 100, Mobile, AL 36604

Date: 23 Oct 01

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NOV 05 2001

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.bomex.org

Form 3
Postgraduate Training Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECT to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258. Your prompt response will be appreciated.

Name: SAMUEL AUERBACH MD, M.D.

Samuel Auerbach MD — 6-15-01
Signature — Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved postgraduate training in the United States or Canada.

This is to certify that Samuel L. Auerbach, M.D. undertook and satisfactorily completed a full term approved program of 12 (number) months in the Millard Fillmore Hospital (Full name and complete address of Hospital) 3 Gates Circle Buffalo, NY 14209 in the field of Advanced Pelvic Gyn. Surgery from 7/1/93 (Date) (Mo/Day/Yr) to 6/30/94 (Date/Anticipated Date)

and that the said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. Yes ✓ No _____

1. Was applicant ever placed on probation, restricted, or limited? NO If yes, please attach written explanation
2. Was there any reason not to continue applicant in the training program? Yes _____ No ✓
3. Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

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3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation.
4. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes ✓ No _____ If no please attach written explanation.

Signed: Marcia A. Brierley, M.D. (Seal of Hospital)
Title: Director, Medical Staff + Educ.
Address: 3 Gates Circle Bflo NY 14209 Date: 10/23/01

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.bomex.org

Form 3
Postgraduate Training Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECT to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258. Your prompt response will be appreciated.

Name: SAMUEL AUERBACH MD, M.D.

Samuel Auerbach MD 6-15-01
Signature Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved postgraduate training in the United States or Canada.

This is to certify that Samuel Auerbach, MD, M.D. undertook and satisfactorily completed a full term approved program of 12 (number) months in the VAN NUYS BRAIN CENTER (Full name and complete address of Hospital) VAN NUYS, CALIFORNIA in the field of BRAIN MEDICINE from 9-19-94 (Date) (Mo/Day/Yr) to 9-18-95 (Date/Anticipated Date)

and that the said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. Yes _____ No ✓

1. Was applicant ever placed on probation, restricted, or limited? NO If yes, please attach written explanation
2. Was there any reason not to continue applicant in the training program? Yes _____ No ✓
3. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation.
4. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes ✓ No _____ If no please attach written explanation.

Signed: _____, M.D. (Seal of Hospital)

Title: Professor of Surgery

Address: USC - Norris Cancer Ctr
1441 EAST LAKE
LA, CA 90049

Date: 10-15-01

FEDERATION LICENSING EXAMINATION (FLEX)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Arizona Board of Medical Examiners
ATTN: Claudia Foutz
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258

EXAMINEE: Auerbach, Samuel Louis
USMLE ID#: 2-145-594-4
DOB: [redacted]
ALT. NAME(S):

It is certified that the above named physician took the Federation Licensing Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: [redacted] **Date of Certification:** **8/31/01**

Examination Date:	06/83	12/82
State Taken For:	005	005
BASIC SCIENCE		
Anatomy:	69.00	62.00
Physiology:	64.00	64.00
Biochemistry:	69.00	67.00
Pathology:	77.00	72.00
Microbiology:	69.00	67.00
Pharmacology:	76.00	74.00
Behavioral Science:	70.00	76.00
Basic Science Avg:	70.57	68.85
CLINICAL SCIENCE		
Medicine:	74.00	76.00
Surgery:	75.00	69.00
Obstetrics:	76.00	76.00
Public Health:	75.00	72.00
Pediatrics:	82.00	69.00
Psychiatry:	70.00	69.00
Clinical Science Avg:	75.33	71.83
Clinical Comp Avg:	73.57	73.25
Flex Weighted Avg:	73.00	72.00

RECEIVED
SEP 04 2001

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

FEDERATION LICENSING EXAMINATION (FLEX)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Arizona Board of Medical Examiners
ATTN: Claudia Foutz
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258

EXAMINEE: Auerbach, Samuel Louis
USMLE ID#: 2-145-594-4
DOB: [redacted]
ALTERNATE NAME(S):

It is certified that the above named physician took the Federation Licensing Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: [redacted]

Date of Certification: **08/31/2001**

Date of Exam	State Exam Taken For	State ID	Comp 1	Comp 2
12 / 1992	NEW YORK	00187	75	
6 / 1992	NEW YORK	00153	73	
12 / 1991	NEW YORK	00430	74	
6 / 1991	NEW YORK	00739	73	
12 / 1990	NEW YORK	00328	72	75
6 / 1990	NEW YORK	00003	73	74

COMPONENT 1 of FLEX is designed to evaluate measurable aspects of the knowledge and understanding of basic and clinical sciences, with specific emphasis on principles and mechanisms underlying disease and modes of therapy.

COMPONENT 2 of FLEX is designed to assess the additional cognitive abilities required of physicians who will ultimately assume independent responsibilities for the general health care of patients.

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

Arizona State Board of Medical Examiners

9545 E. Doubletree Ranch Road – Scottsdale AZ 85258-5514
Home Page: http://www.bomex.org Email: questions@bomex.org
Telephone (480) 551-2700 • Toll Free (877) 255-2212 • Fax (480) 551-2704

December 14, 2001

Samuel L. Auerbach, MD

Dear Dr. Auerbach:

Congratulations! Your license # 29924 to practice medicine in the State of Arizona was issued December 14th, and your certificate and wallet registration card are enclosed.

Enclosed is a copy of the Arizona State Medical Board's Professional Directory and Resource Handbook. It is suggested that you familiarize yourself with the provisions of the Handbook prior to establishing your practice in Arizona.

ARS §321435 states that each person holding a current license to practice medicine in Arizona shall promptly and in writing inform the Board of their current residence, office address and telephone number and of each change in residence and office address or telephone number. In addition the Board may assess the cost of locating a licensee and a penalty of not to exceed one hundred dollars against a licensee who fails to comply with these provisions within thirty days from the date of change.

Please contact Marie Slaughter, Licensing and Renewals Administrator, at (480) 551-2756, if you have any questions.

Sincerely,

Claudia Foutz

Claudia Foutz
Executive Director

Enclosures: Receipt

cc: File

Arizona State Board of Medical Examiners

9545 E. Doubletree Ranch Road – Scottsdale AZ 85258-5514
Home Page: http://www.bomex.org Email: questions@bomex.org
Telephone (480) 551-2700 • Toll Free (877) 255-2212 • Fax (480) 551-2704

December 3, 2001

Samuel Louis Auerbach, M.D.
18615 Burbank Boulevard, Suite 214
Tarzana, California 91356

Dear Dr. Auerbach:

The Arizona State Board of Medical Examiners is pleased to inform you that your application for licensure in the State of Arizona has been approved. Your license will be issued upon receipt of the required statutory license registration fee A.R.S. 32-1436(A)(2) and is renewable on your birthday [redacted]

The legislation enacting the initial licensing fee was signed into law in April 2000 and implemented by the Board effective September 1, 2000. As of January 2001 Arizona converted to biennial licensure based on birth month and odd or even birth year. Your required license registration fee is $375.00. Please complete the bottom portion of this letter and return the completed form with the initial license registration fee in the enclosed envelope. Note, the residential address and phone number are not available to the public unless they are the only address and number of record. You are not permitted to commence the practice of medicine in the State of Arizona until your license has been issued.

If you have any questions, please contact me by e-mail at MSlaughter@bomex.org or by telephone at (480) 551-2756.

Sincerely,

Marie Slaughter

Marie Slaughter
Licensing and Renewals Administrator

(DO NOT DETACH)

Name: SAMUEL LOUIS AUERBACH MD

Office Address: 1037 WEST AVE N; PALMDALE CA 93551

Home Address: [redacted]

Mailing Address: [redacted]

Office Telephone Number: (818) 609 9070 Home Telephone Number: [redacted]

Field of Practice: GYN/OB + INT. MED

cc: File

Arizona State Board of Medical Examiners
9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258
Home Page: http://www.bomex.org
Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

DEFICIENCY NOTICE
(R4-16-104)

February 1, 2001

Samuel Louis Auerbach, M.D.

Dear Dr. ~~Allerbach~~ Auerbach:

This will acknowledge receipt of your application for licensure to practice medicine in the State of Arizona.

Enclosed please find receipt #102562 covering statutory fee of $500.00.

Licensing staff has reviewed your application and determined that it is deficient. To complete the processing of your application the Board requires the following information and/or documentation:

(1) ✓ **Medical College Certification from Universidad Del Norte** 11/2/01
(2) ✓ **Postgraduate Training Certification from the following:**
- ✓ **State Univesity of New York-Buffalo (Fifth Pathway Program for period July 1, 1983 to June 30, 1984.** 6/28/01
- ✓ **Millard Fillmore Hospital for period July 1, 1984 t oJune 30, 1985.** 11/5/01
- ✓ **Mount Sinai Hospital/Bronx Veterans Administration Medical Center for peirod July 1, 1985 to June 30, 1986.** 7/10/01
- ✓ **State University of New York at Syracuse for period July 1, 1986 to June 30, 1987.** 7/10/01
- ✓ **Albany Medical Center for period July 1, 1987 to June 30, 1988** 6/28/01
- ✓ **Lutheran Medical Center for period July 1, 1988 to June 30, 1989.** 6/25/01
- ✓ **University of Southern Alabama Medical Center for period July 1, 1989 to June 30, 1991.** 10-26-01
- ✓ **State University of New York at Buffalo for period July 1, 1993 to June 30, 1994.** 11/6/01
- ✓ **Melvin Silverstein, M.D. for period July 1, 1994 to June 30, 1995.** 10/19/01

(3) ✓ **ECFMG** 9/10/01
(4) ✓ **Exam scores: USMLE, NBME, FLEX, or State Written Exam** 9/4/01
(5) ✓ **AMA Physician Profile** 8/24/01
(6) ✓ **National Practioners Data Bank (self query)** 10/26/01
(7) ✓ **Home Address Supplement form** 8/24/01
(8) ✓ **Social Security Supplement form** 9.7.01 ✓ 8-28-01 9.10.01
(9) **License verification from the following:** ✓ **New York** and ✓ **California** NV, NJ, AL 10/25/01
(10) ✓ **Federation of State Medical Boards-Displinary Data Bank** 8-24-01
(11) ✓ **List of all hospital affiliation and/ or medical employment with verification for the past five years.** 8/24/01
(12) ✓ **Need the front page of the application with a photo. Please sign the bottom portion of that photo.**
(13) ✓ **Evidence of name and date of birth: certified birth certificate or passport** 10/19/01

Please be advised final action cannot be taken until the required information is in your application file. It is your responsibility to ensure that the Board receives all documentation.

Samuel Louis Allerbach, M.D.
February 1, 2001

Further, please be advised that if your application is not fully complete within one year from this date, including participation in written SPEX/USMLE Examination (if applicable), your application is deemed withdrawn.

When your application is approved, you will be notified of the initial licensing fee due for issuance of your license.

If you have questions, please contact Michelle Adams at e-mail madams@BOMEX.Org or (480) 551-2759.

Sincerely,

Marie Slaughter

Marie Slaughter
Licensing and Renewals Administrator

Enclosures
cc: file

STATE OF ALABAMA MEDICAL LICENSURE COMMISSION

POST OFFICE BOX 887 MONTGOMERY, ALABAMA 36101-0887 Phone: (334)242-4153

JERRY N. GURLEY, M.D., CHAIRMAN/EXECUTIVE OFFICER • CINDY D. WEBER, EXECUTIVE ASSISTANT

ARIZONA BOARD OF MEDICAL EXAMINERS
9545 EAST DOUBLETREE RANCH ROAD
SCOTTSDALE, AZ 85258

VERIFICATION OF ALABAMA MEDICAL LICENSURE

Name of Licensee (as it appears in our records):

SAMUEL LOUIS AUERBACH

Date of Birth:	[redacted]
Soc Sec #:	[redacted]
License#:	**MD. 00024126**
Current Status:	**ACTIVE IN RENEWAL**
Date Issued:	**06/27/2001**
Basis of License:	**FLEX/NY**
Expiration Date:	**12/31/2001**
Medical School:	**SCH OF MED UNIV OF NORTHEAST TAMPICO**
Location:	**TAMPICO**
Date From/To:	**8/76-6/80**

Disciplinary Actions:

[SEAL]

[✓] NO
[ ] Yes, See Attached
[ ] Other, See Attached

Signature: _____

Jerry N. Gurley, M.D.
Chairman, Medical Licensure
Commission of Alabama

Date: **October 23, 2001**

To expedite the verification process, the above is the standard format used by the Medical Licensure Commission of Alabma. Verification information can also be obtained by accessing our web site at **http://www.albme.org/**

Completed by: Joyce M Duggan
Verification Clerk

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
http://www.docboard.org/pomex

RECEIVED
SEP 10 2001

Form 4
State Licensure Verification

THIS IS NOT AN ENDORSEMENT CERTIFICATION

Please complete this section of the form and mail to the state board in which you are currently licensed or were previously licensed to practice medicine. *(If this is your initial licensure, this form is not needed.)*
Please print one form to be sent to each state wherein you hold or ever held licensure.

Name: SAMUEL L. AUERBACH (Please Print), M.D. MA-65075 (NEW JERSEY) License Number

Signature: Samuel L Auerbach

This section to be completed by an official of the State Board and sent direct to the Arizona State Board of Medical Examiners at the above address.

To Whom It May Concern:

In applying for a license to practice medicine in the State of Arizona, the medical board requires this form to be completed by each state wherein I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise. Please forward this information *direct* to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road; Scottsdale, Arizona 85258. Your immediate attention to this request is appreciated.

State: New Jersey

Full Name of Licensee: Samuel L Auerbach, M.D.

Graduate of: N/A

License number: MA65075 Issue Date: 12-2-96 (Month/Day/Year)

By Endorsement or Reciprocity with: _____

By your State Board's written examination/FLEX/SPEX/USMLE: Flex Endorsement

Is license current? ☑ Yes ☐ No If no, why not? _____

Derogatory information, if any: NONE

LICENSE IN GOOD STANDING
NO DEROGATORY INFORMATION

Name of person completing the form (please print) Title

William V. Roeder
WILLIAM V. ROEDER, EXEC. DIR.
Signature

SEP 06 2001
Date (Month/Day/Year)

STAMP OR SEAL OF BOARD
IF NO SEAL, PLEASE INDICATE

Please use other side for any additional comments.

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 HOWE AVE, SUITE 56
SACRAMENTO CA 95825-3236
TELEPHONE: (916) 263-2382
FAX: (916) 263-2944

www.medbd.ca.gov

August 29, 2001

ARIZONA BOARD OF MEDICAL EXAMINERS
PO BOX 6200
SCOTTSDALE AZ 85261-6200

To Whom It May Concern:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

Physician:	SAMUEL LOUIS AUERBACH
License No.:	A 53310
Issued:	July 27, 1994
Exam Type:	A written examination
Expiration Date:	August 31, 2001
Status:	Renewed/current

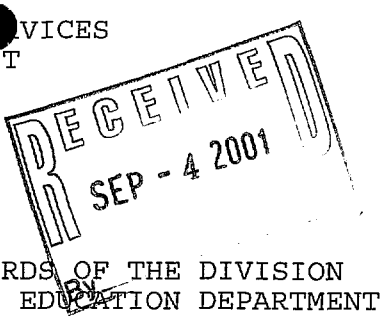
If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File Room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

M. Elizabeth Ware

M. ELIZABETH WARE
Chief, Division of Licensing

SEAL

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CERTIFICATION & VERIFICATION UNIT
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234



THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, AUERBACH SAMUEL LOUIS
WAS ISSUED LICENSE/CERTIFICATE NUMBER 191774 FOR THE PRACTICE OF MEDICINE ON 03/23/93.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: [redacted]
SCHOOL ATTENDED: UNIVERSITY DEL NORESTE
DATE OF GRADUATION: 06/06/80
DEGREE EARNED: PHY&SR

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:

DATE	COMP1	COMP2	FLEX EXAMINATION
12/92	00075		
12/90	00072	00075	

EXMS TAKEN=09

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: YES REG PERIOD ENDS: 07/31/03
ADDRESS: [redacted]

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I FRANK GEBOSKY, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

Frank Gebosky 08/28/01
PRINCIPAL CLERK

OP026 044

Nevada State Board of Medical Examiners

VERIFICATION OF LICENSURE

This is to certify that the records of the Nevada State Board of Medical Examiners indicate the following information regarding:

Samuel L Auerbach, M.D.
[redacted]

LICENSE TYPE:	Medical Doctor		
LICENSE NUMBER:	7617	CURRENT STATUS:	Active
EFFECTIVE DATE:	11/22/1995	DISCIPLINARY ACTION:	NONE
EXPIRATION DATE:	06/30/2003	EXAMINATION LICENSED BY *:	FX

* KEY:	FX	= Federation Licensing Examination
	NB	= National Boards
	USMLE	= United States Medical Licensing Examination
	LMCC	= Canadian Medical Licensing Examination
	State Abbreviation	= If Licensed by a State's Basic Sciences Examination

We are not in a position to advise whether the above person is currently under investigation by the Nevada State Board of Medical Examiners. Until such time as an investigation of any person licensed by the board is culminated by the filing of a formal complaint, we are not in a position to reveal the facts or the nature of any investigation. We have, however, searched our records and do not find that any formal disciplinary action has been taken against the above person by the board.

To expedite the verification of licensure process, the above is the standard format for verification of licensure of all persons licensed by the Nevada State Board of Medical Examiners.

Larry D. Lessly, J.D., Executive Director

Dated: 08/24/2001

1105 Terminal Way, Suite 301 • (775) 688-2559 • Fax 688-2321
Mailing Address: Post Office Box 7238 • Reno, Nevada 89510

Arizona Board of Medical Examiners
9545 E. Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
http://www.docboard.org/bomex

Form 5
Federation of State Medical Boards
Data Bank Report

Applicant is to complete this form and forward the completed form to the ***Federation of State Medical Boards*** at the address below:

Coordinator, Disciplinary Data Bank
The Federation of State Medical Boards
400 Fuller Wiser Road
Euless, Texas 76039

RECEIVED
AUG 28 2001
By

The Arizona Board of Medical Examiners requests a disciplinary search concerning the following individual.

Type or legibly print the following information:

Name: AUERBACH (Last) SAMUEL (First) LOUIS (Middle)

Birth Date (Month/Day/Year): [redacted]

Medical School of Graduation and Branch Location: UNIVERSIDAD DEL NORESTE; TAMPICO TAMPS MEXICO

Date of Graduation (Month/Day/Year): 6-6-80

Physician (applicant's) Signature: Samuel Louis Auerbach MD

Date signed (Month/Day/Year): 8-1-01

Federation of State Medical Boards Comments:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

AUG 27 2001

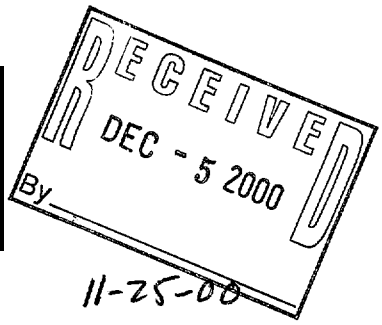
DALE L. AUSTIN
INTERIM CHIEF OPERATING OFFICER

FSMB, Please return this competed form directly to the Arizona State Board of Medical Examiners, 9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258. Thank you.

A2

SAMUEL AUERBACH, M.D.

[redacted]



11-25-00

Please Note

Additional information will follow as soon as possible

Please pardon the delay

Sincerely

Samuel Auerbach

SAMUEL AUERBACH MD

CK 51994 150

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2704
Website: www.azmd.gov

RECEIVED
JUN 20 2014
AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Samuel Louis Auerbach, MD

MD LICENSE #: 29924 SPECIALTY:_____

X Renewal Registration ($150) (Renewal & fee must come together postmarked or faxed by 6/30)

- Confirm ALL locations below where you will be dispensing prescription drugs, devices and controlled substances. (For each location, place a check mark to verify address and schedule of drugs dispensed from each location are correct)
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.
- Blank form attached to add additional locations

PLEASE NOTE

A **separate** DEA license must be submitted for ***EACH*** location where **controlled substances** will be dispensed and must be kept current during the registration period

1615 E OSBORN RD
PHOENIX, AZ 85016

Schedule II Drugs
Schedule III Drugs
Schedule IV Drugs
Schedule V Drugs
Nubain
Prescription Only Drugs
Prescription Devices

X Dispensing location information correct X Copy of DEA attached ☐ Remove this location

Physician's Signature: Samuel Auerbach Date: 6/1/14

ENTERED

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172-000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	06-30-2014	$551

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	05-26-2011

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	06-30-2014	$551

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	05-26-2011

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172

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FORM DEA-223 (4/07)

5/1444

RECEIVED
MAY 20 2013
AZ MEDICAL BOARD

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2704
Website: www.azmd.gov

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Samuel Louis Auerbach, MD

MD LICENSE #: 29924 **SPECIALTY:** GYN

☑ **Renewal Registration ($150) (Renewal & fee must come together postmarked or faxed by 6/30)**

- Confirm ALL locations below where you will be dispensing prescription drugs, devices and controlled substances. (For each location, place a check mark to verify address and schedule of drugs dispensed from each location are correct)
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.
- Blank form attached to add additional locations

PLEASE NOTE

A **separate** DEA license must be submitted for ***EACH*** location where **controlled substances** will be dispensed and must be kept current during the registration period

1615 E OSBORN RD
PHOENIX, AZ 85016

Schedule II Drugs
Schedule III Drugs
Schedule IV Drugs
Schedule V Drugs
Nubain
Prescription Only Drugs
Prescription Devices

☑ Dispensing location information correct ☑ Copy of DEA attached ☐ Remove this location

Physician's Signature: _____ Date: 5/9/13

ENTERED

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172-000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	06-30-2014	$551

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	05-26-2011

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

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CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	06-30-2014	$551

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	05-26-2011

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172

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Form DEA-223 (4/07)

PHYSICIAN NAME: Samuel Louis Auerbach, MD
MD LICENSE #: 29924

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

Arizona Medical Board
9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258 -5514
Telephone: 480 -551-2700 • Toll Free: 877 -255-2212 • Fax: 480 -551-2704
Website: wwwazmd.gov

May 07, 2013

Samuel Louis Auerbach, MD
1615 East Osborn Road
Phoenix, AZ 85016

License # 29924

RE: RENEWAL OF DISPENSING PHYSICIAN REGISTRATION FOR FISCAL YEAR 2013 - 2014

Enclosed please find an application for renewal of your Dispensing Physician Registration(s) for FY 2013 - 2014 . **Your current registration(s) will expire on 06/30/2013.**

Please complete the enclosed application in its entirety and return with your **$150** renewal payment and DEA certificate(s) as appropriate, postmarked on or before June 30th to ensure timely issuance of your dispensing certificate(s) for the new fiscal year. Please note that one $150 renewal fee covers all dispensing locations for the year. Please make your check, cashier's check or money order payable to **ARIZONA MEDICAL BOARD** or if paying by Visa, MasterCard or American Express (use credit card authorization form attached) and mail or fax with renewal documents. Please note that we cannot accept post-dated checks.

Mail your application and fee to:
Arizona Medical Board
9545 E. Doubletree Ranch Rd.,
Scottsdale, AZ 85258-5514

If the completed annual renewal form, all required documentation and the correct fee are not received at the Board's office postmarked on or before June 30, 2013, the physician "shall not dispense drugs and devices until newly registered". This would require completion of an "initial" registration at a fee of $200. R4-16-301(C)

If you have questions, please contact the board by phone at (480) 551-2700.

Sincerely,

The Arizona Medical Board
www.azmd.gov

RECEIVED
MAY 14 2012
AZ MEDICAL BOARD

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2704
Website: www.azmd.gov

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

Dr# 50923

PHYSICIAN NAME: Samuel Louis Auerbach, MD

MD LICENSE #: 29924 **SPECIALTY:** GYN

☐ **Renewal Registration ($150) (Renewal & fee must come together postmarked or faxed by 6/30)**

- Confirm ALL locations below where you will be dispensing prescription drugs, devices and controlled substances. (For each location, place a check mark to verify address and schedule of drugs dispensed from each location are correct)
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.
- Blank form attached to add additional locations

PLEASE NOTE

A **separate** DEA license must be submitted for ***EACH*** location where **controlled substances** will be dispensed and must be kept current during the registration period

1615 E OSBORN RD
PHOENIX, AZ 85016

Schedule II Drugs
Schedule III Drugs
Schedule IV Drugs
Schedule V Drugs
Nubain
Prescription Only Drugs
Prescription Devices

☒ Dispensing location information correct ☒ Copy of DEA attached ☐ Remove this location

Physician's Signature: Samuel Louis Auerbach MD Date: 5/11/12 (F)

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172-000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	06-30-2014	$551

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	05-26-2011

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	06-30-2014	$551

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	05-26-2011

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172

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Form DEA-223 (4/07)

CK 50339
$150-

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2704
Website: www.azmd.gov

RECEIVED
MAY 16 2011
AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Samuel Louis Auerbach, MD

MD LICENSE #: 29924 **SPECIALTY:** GYN/OB

☑ **Renewal Registration ($150) (Renewal & fee must come together postmarked or faxed by 6/30)**

- Confirm ALL locations below where you will be dispensing prescription drugs, devices and controlled substances. (For each location, place a check mark to verify address and schedule of drugs dispensed from each location are correct)
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- Blank form attached to add additional locations

PLEASE NOTE

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1615 E OSBORN RD
PHOENIX, AZ 85016

Schedule II Drugs
Schedule III Drugs
Schedule IV Drugs
Schedule V Drugs
Nubain
Prescription Only Drugs
Prescription Devices

☑ Dispensing location information correct ☑ Copy of DEA attached ☐ Remove this location

Physician's Signature: Samuel Louis Auerbach Date: 5-12-11

Acacia Women's Center
Complete Gynecological Care

Phone: (602) 462-5559
Fax: (602) 667-6608

1615 East Osborn Road
Phoenix, Arizona 85016
www.abortionclinicsarizona.com

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	06-30-2011	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	06-03-2008

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

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CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	06-30-2011	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	06-03-2008

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172

Sections 304 and 1008 (21 USC 824 and 958) of t
Controlled Substances Act of 1970, as amend
provide that the Attorney General may revoke
suspend a registration to manufacture, distribu
dispense, import or export a controlled substance.

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Form DEA-223 (4/07)

RECEIVED
MAY 10 2010
AZ MEDICAL BOARD

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Samuel Louis Auerbach, MD

MD LICENSE #: 29924 **SPECIALTY:** GYNECOLOGY + BREAST MEDICINE

☐ **Renewal Registration ($150) (Renewal & fee must come together postmarked or faxed by 6/30)**

- Confirm ALL locations below where you will be dispensing prescription drugs, devices and controlled substances. (For each location, place a check mark to verify address and schedule of drugs dispensed from each location are correct)
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.
- Blank form attached to add additional locations

[redacted]

1615 E OSBORN RD ✓
PHOENIX, AZ 85016

Schedule II Drugs ✓
Schedule III Drugs ✓
Schedule IV Drugs ✓
Schedule V Drugs ✓
Nubain ✓
Prescription Only Drugs ✓
Prescription Devices ✓

☑ Dispensing location information correct ☑ Copy of DEA attached ☐ Remove this location

Physician's Signature: Samuel Louis Auerbach Date: 5-10-2010

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172-000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	06-30-2011	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	06-03-2008

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

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THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	06-30-2011	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	06-03-2008

AUERBACH, SAMUEL MD
1615 EAST OSBORN ROAD
PHOENIX, AZ 85016-7172

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (4/07)

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

CK 12921 $150 wrong amount

RECEIVED JUL 16 2009 AZ MEDICAL BOARD

postmarked Jul 4/15

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Samuel Louis Auerbach, MD

MD LICENSE #: 29924 **SPECIALTY:**_____

CK 12931 $50

total amount $200

☑ **Renewal Registration ($150) (Renewal & fee must come together postmarked or faxed by 6/30)**

- Confirm ALL locations below where you will be dispensing prescription drugs, devices and controlled substances. (For each location, place a check mark to verify address and schedule of drugs dispensed from each location are correct)
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.
- Blank form attached to add additional locations

PLEASE NOTE
A **separate** DEA license must be submitted for ***EACH*** location where **controlled substances** will be dispensed and must be kept current during the registration period.

1615 E OSBORN RD
PHOENIX, AZ 85016

Schedule II Drugs
Schedule III Drugs
Schedule IV Drugs
Schedule V Drugs
Nubain
Prescription Only Drugs
Prescription Devices

☑ Dispensing location information correct ☐ Copy of DEA attached ☐ Remove this location

Physician's Signature: Samuel Auerbach Date: 5/23/09

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

RECEIVED MAY 23 2008

PHYSICIAN NAME: SAMUEL LOUIS AUERBACH, MD

LICENSE #: 29929

CK 12609 AM BUS

Renewal Registration FEE ($150) If received by June 30, 2008

PLEASE NOTE

A ***separate*** DEA license must be submitted for ***EACH*** location where controlled substances will be dispensed and must be kept current during the registration period

Place a check mark next to description below of all items which will be dispensed from all locations. (Certificate will be issued only for items that are checked)

Schedule II Drugs	✓	Schedule III Drugs	✓	Prescription-Only Drugs	✓	Nubain	✓
Schedule IV Drugs	✓	Schedule V Drugs	✓	Prescription Devices	✓		

Your certificate will be issued for Prescription-Only Drugs and Devices if a DEA registration is not submitted for *each location.*

PRIMARY PRACTICE LOCATION:

1615 EAST OSBORN ROAD PHOENIX, AZ 85016 602-462-5559

Street Address City, State, Zip Code Phone #

[redacted] 6-21-05 6-30-08 ✓

DEA # for this location (Attach Copy of DEA) Issued Date Expiration Date 6/30/11

ADDITIONAL PRACTICE LOCATION:

Street Address City, State, Zip Code Phone #

DEA # for this location (Attach Copy of DEA) Issued Date Expiration Date

Physician's Signature: Samuel Louis Auerbach Date: 5/16/08

Renewal registration fee: $150.00 *per physician*

ENTERED 6/5 5/27/08

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

If you wish to pay by payment card, please complete the attached PAYMENT CARD AUTHORIZATION FORM

OCT-25-2007 11:48 AMB P.02/03

pd ck 12098 $200

RECEIVED

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

OCT 29 2007

ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

PHYSICIAN NAME: Samuel Auerbach M.D.

LICENSE #: 29924 SPECIALTY: gynecology

CHECK ONE: ☒ Initial Registration ($200) ☐ Renewal Registration ($150)

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE

A *separate* DEA license must be submitted for ***EACH*** location where controlled substances will be dispensed and must be kept current during the registration period

PRIMARY PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** [redacted] 30/08

Street Address				City/State/Zip Code			
1615 East Osborn Rd				Phoenix AZ 85016			
Phone Number				**Fax Number**		**E Mail**	
602 462 5559				6026676608			
Schedule II Drugs	✓	Schedule III Drugs	✓	Prescription-Only Drugs	✓	Nubain	
Schedule IV Drugs	✓	Schedule V Drugs	✓	Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				**Fax Number**		**E Mail**	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

**** List any additional locations on the reverse side of this form and place a check mark here:** ☐

Physician's Signature: Samuel Auerbach Date: 10-26-07

Initial registration fee: $200.00 *per physician*

Renewal registration fee: $150.00 *per physician*

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

If you wish to pay by payment card, please complete the attached PAYMENT CARD AUTHORIZATION FORM

ck # 12098 Enclosed

SEP-05-2006 11:19 P.02

RECEIVED BY. AUG 14 2006 ARIZONA MEDICAL BOARD OPERATIONS

CR 11101 $200

RECEIVED JUL 31 2006

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258 Telephone: (480) 551-2761 Fax (480) 551-2704
Home Page: http://www.azmdboard.org

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Samuel Averbach MD

LICENSE #: 29924 SPECIALTY: gynecology

CHECK ONE: ☒ Initial Registration ($200) Practice location change ☐ Renewal Registration ($100)

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE
A *separate* DEA license must be submitted for *EACH* location where controlled substances will be dispensed and must be kept current during the registration period.

PRIMARY PRACTICE LOCATION: DEA # FOR THIS LOCATION: [redacted] 4/30/08

Street Address			City/State/Zip Code
1615 East Osborn Road			Phoenix AZ 85016
Phone Number		Fax Number	E Mail
602-462-5559		602-667-6608	[redacted]
Schedule II Drugs ✓	Schedule III Drugs ✓	Prescription-Only Drugs ✓	Nubain ✓
Schedule IV Drugs ✓	Schedule V Drugs ✓	Prescription Devices ✓	

ADDITIONAL PRACTICE LOCATION: DEA # FOR THIS LOCATION:

Street Address			City/State/Zip Code
Phone Number		Fax Number	E Mail
Schedule II Drugs	Schedule III Drugs	Prescription-Only Drugs	Nubain
Schedule IV Drugs	Schedule V Drugs	Prescription Devices	

*** List any additional locations on the reverse side of this form and place a check mark here: ☐

Physician's Signature: Samuel Averbach 7-30-06 and Date: 8-10-06

Initial registration fee: $200.00 *per physician* - Renewal registration fee: $100.00 *per physician*

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

If you wish to pay by payment card, please complete the attached PAYMENT CARD AUTHORIZATION FORM

1716

MAR-01-2005 07:45 P.02/10

RECEIVED MAR 8 2005 BY

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmdboard.org

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Samuel Averbach MD

LICENSE #: 29924 SPECIALTY: gynecology

CHECK ONE: [X] Initial Registration ($200) [ ] Renewal Registration ($100)

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE
A *separate* DEA license must be submitted for *EACH* location where controlled substances will be dispensed and must be kept current during the registration period.

PRIMARY PRACTICE LOCATION: DEA # FOR THIS LOCATION: [redacted] 6/30/05

Street Address	City/State/Zip Code	
3417 North 32 St	Phoenix AZ 85016	
Phone Number	**Fax Number**	**E Mail**
602 462 5559	602 667 6608	

Schedule II Drugs	✓	Schedule III Drugs	✓	Prescription-Only Drugs	✓	Nubain	✓
Schedule IV Drugs	✓	Schedule V Drugs	✓	Prescription Devices	✓		

ADDITIONAL PRACTICE LOCATION: DEA # FOR THIS LOCATION:

Street Address			City/State/Zip Code		
Phone Number			**Fax Number**		**E Mail**
Schedule II Drugs		Schedule III Drugs	Prescription-Only Drugs		Nubain
Schedule IV Drugs		Schedule V Drugs	Prescription Devices		

List any additional locations on the reverse side of this form and place a check mark here: [ ]

Physician's Signature: Samuel Averbach Date: 3/4/05

Initial registration fee: $200.00 per physician Renewal registration fee: $100.00 per physician

Make checks or money orders payable to ARIZONA MEDICAL BOARD.

For your convenience, we accept payments by Visa or MasterCard.

If you wish to pay by payment card, please complete the attached PAYMENT CARD AUTHORIZATION FORM.

9004

RECEIVED JUN 23 2003

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmdboard.org

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Samuel Averbach MD

LICENSE #: 29924 SPECIALTY: Gynecology

CHECK ONE: ☐ Initial Registration ($200) ☒ Renewal Registration ($100)

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE
A *separate* DEA license must be submitted for *EACH* location where controlled substances will be dispensed and must be kept current during the registration period.

PRIMARY PRACTICE LOCATION: DEA # FOR THIS LOCATION: [redacted] 2/12/02 6/30/05

Street Address				City/State/Zip Code			
3417 N 32 St Phx AZ 85018				Phoenix AZ 85018			
Phone Number				Fax Number		E Mail	
602-462-4999				602 667-6608			
Schedule II Drugs	✓	Schedule III Drugs	✓	Prescription-Only Drugs	✓	Nubain	✓
Schedule IV Drugs	✓	Schedule V Drugs	✓	Prescription Devices	✓		

ADDITIONAL PRACTICE LOCATION: DEA # FOR THIS LOCATION:

Street Address				City/State/Zip Code			
None							
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

List any additional locations on the reverse side of this form and place a check mark here: ☐

Physician's Signature: X [signature] Date: 6-14-03

Initial registration fee: $200.00 *per physician* . Renewal registration fee: $100.00 *per physician*

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

If you wish to pay by payment card, please complete the attached PAYMENT CARD AUTHORIZATION FORM

Please mail or fax this form to:

Arizona Medical Board
Arizona Regulatory Board of Physician Assistants
Attention: Licensing Office
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258
Fax: 480-551-2704

ADDRESS CHANGE FORM

- You must notify the board in writing within 30 days of any change of office or home address and phone number
- Failure to do so may result in a monetary fine of $100 plus the costs incurred by the Board to locate you
- Please print this from and provide all information on your address change as requested below. Please type or print legibly. Fax or mail the completed form to the Board
- In accordance with A.R.S. §32-3801, notwithstanding any law to the contrary, a professional's residential address and residential telephone number or numbers maintained by the professional board established pursuant to this title are not available to the public unless they are the only address and numbers of record.

Please record the following address changes: **EFFECTIVE DATE:** 10-26-07

PRACTICE: Acacia Womens Center (Company Name) (If you do not have a practice address or name write the word "NONE")

Street Address Only: 1615 East Osborn Rd
(list P.O. Box as Mailing Address below)*

City: Phoenix **State:** AZ **Zip:** 85016

Office Telephone: 602 462 5559 **Office Fax:** 602 667 6608

Office E-Mail: —

RESIDENCE ADDRESS: [redacted]

City: [redacted] **State:** [redacted] **Zip:** [redacted]

Telephone: — **Cell Phone:** [redacted]

Residence E-Mail: —

MAIL SHOULD BE SENT TO MY: Practice ☒ Residence ☐ The Address Below ☐

MAILING ADDRESS: _____
(If different from either above)

Street or P.O. Box: _____

City: _____ **State:** _____ **Zip:** _____

****If no practice address, do you want your home address listed on the website?** Yes ☐ No ☐

Samuel Applebaum
Name (Please print)

29924
AZ License #

Samuel Applebaum
Signature

10-26-07
Today's Date

W

Arizona Medical Board: License Renewal Questions

Samuel	Auerbach		2013	License # 29924	Professional Conduct

1. Since your last renewal have you had an application for medical licensure denied or rejected by another state or province licensing board?	**No**	
2. Since your last renewal has disciplinary or rehabilitative action been taken against you by another licensing board, including other health professions?	**No**	
3. Since your last renewal have any disciplinary actions, restrictions or limitations taken against you while participating in any type of training program or by any health care provider?	**No**	
4. Since your last renewal have you been found in violation of a statute, rule, or regulation of any domestic or foreign governmental agency?	**No**	
5. Since your last renewal have you been under investigation by any medical board or peer review body?	**No**	
6. Since your last renewal, have you had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation during an investigation or entered into a consent agreement or stipulation?	**No**	
7. Since your last renewal, have you had hospital privileges revoked, denied, suspended, or restricted?	**No**	
8. Since your last renewal, have you been named as a defendant in a malpractice matter currently pending or that resulted in a settlement or judgment against you?	**No**	
9. Since your last renewal, have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government?	**No**	
10. Since your last renewal, have you had your authority to prescribe, dispense, or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency?	**No**	
11. Since your last renewal, have you engaged or do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication?	[redacted]	[redacted]
12. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state?	**No**	

Arizona Medical Board: License Renewal Questions

Samuel	Auerbach	2013	License # 29924	Mental Health

1. Since your last renewal have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine including a diagnosis or treatment for any psychotic disorder or substance abuse disorder?

[redacted]

2. Since your last renewal, have you consumed intoxicating beverages resulting in your ability being impaired or limited to exercise the judgment and skills of a medical professional?

[redacted]

Arizona Medical Board

Biennial MD LICENSE RENEWAL APPLICATION

9545 E Double Tree Ranch Rd., Scottsdale, AZ 85258

Phone: 480-551-2700 Email Additional Information: LicensingReport@azmd.gov

OL 51574
$500

RECEIVED
AUG 13 2013
AZ MEDICAL BOARD

☐ **License Fee $500** (if postmarked by due date)

☐ **$850** if postmarked 30 days after due date

BEFORE COMPLETING THIS RENEWAL FORM: Please review your physician profile, located at www.azmd.gov. If any of the information is incorrect, please print a copy, line out the erroneous information, write in the correct information and submit it with your renewal. You are subject to discipline if you provide erroneous information. Please note that name changes must be made under separate cover.

REMEMBER: *There is a $25 fee for processing a deficient renewal. Please double check your completed application before mailing.*

First Name: SAMUEL **Initial:** **Last Name:** AUERBACH

License Number: 29924

ADDRESSES:

Office Address: This is the office/principal place of business. The address and phone number will appear in the Medical Directory and on the Board's web site. Every physician must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public. If you want your home address to be listed on your web site profile, please so indicate. Otherwise, no address will be be provided on the profile, but it will be provided to the public if requested.

Mailing Address: If no address is provided, all Board correspondence will be sent to the Office Address.

Email: This address is optional. If you provide an email address, it will not be released to the public.

Home Address: You are required to provide a home address and telephone number. They will not be released to the public *unless* you fail to provide an Office Address.

Practice Name: SAMUEL AUERBACH MD

Office Address: 1615 EAST OSBORN ROAD **City:** PHOENIX **State:** AZ **Zip:** 85016

Office Phone: 602-462-5559 **Office Fax:** 602-667-6608

Mailing Address: 1615 EAST OSBORN ROAD **City:** PHOENIX **State:** AZ **Zip:** 85016

Email:

Home Address: [redacted] **City:** [redacted] **State:** [redacted] **Zip:** [redacted]

Home Phone: [redacted] **Mobile Phone:** [redacted]

PLEASE NOTE: *You are required to notify the Board in writing within 30 days of any change in office or home address and telephone number. A.R.S. §32-1435(B) & (D). There is a fine of $100 for failure to report change of address.*

ENTERED

AMERICAN BOARD OF MEDICAL SPECIALTY (ABMS) CERTIFICATIONS AND FIELDS OF PRACTICE: Please review and correct the fields of practice and ABMS board certification information as shown on your profile. Only certifications from the American Board of Medical Specialties will be shown. Select the field of practice from the drop down list. If you are Board certified, check "yes."

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
GYN/OB	☐ Yes ☑ No	☑ Yes ☐ No	
INT MED	☐ Yes ☑ No	☑ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

PROOF OF CITIZENSHIP: Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States. Federal law, 8 U.S.C. §1641 and State law, A.R.S. §1-501, require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona. Statement of Citizenship and Alien Status available on the website.

☑ **I am a U.S. Citizen or U.S. National.** (If you have not provided the Board with a copy of one of the documents listed in the Statement of Citizenship and Alien Status (i.e. birth certificate, passport, etc) since 2008, please submit a copy with your application.

☐ **I am NOT a U.S. Citizen or U.S. National.** (If this box is checked, you must download, complete and submit with your application an "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents, such as an Alien Registration Card, Visa, etc.)

PROTOCOL FOR STORAGE, TRANSFER AND ACCESS OF PATIENT MEDICAL RECORDS

☑ I am aware that it is unprofessional conduct to fail to have a written protocol in place for the secure storage, transfer and access of patient medical records when a physician terminates or sells his/her practice and the medical records do not remain in the same physical location. I have a protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close, as required by A.R.S. §32-3211.

CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

☑ I have completed a minimum of 40 hours CME during the two previous calendar years of renewal year as required by A.R.S. §32-1434 and A.A.C. §R4-16-101.

****Please do not submit proof of CME unless you received notice on your renewal that you are subject to a CME audit. If an audit was indicated, please submit the CME documentation with your completed renewal.*

REQUEST FOR CHANGE IN LICENSE STATUS: You may request INACTIVATION or CANCELLATION of your license using this form. Do not submit a license renewal fee if you are requesting inactivation or cancellation; however, you must sign and date this form.

☐ **I request INACTIVATION of my medical license.** I am not presently under investigation by the Board, the Board has not commenced disciplinary proceedings against me, and *I am totally retired from the practice of medicine in this state or any state, territory, or district of the United States or foreign country.* I understand that once inactive status is granted, the Board will waive the annual renewal fees and requirements for CME. I understand that I may not engage in the practice of medicine, hold registration with the Drug Enforcement Administration, or write prescriptions as long as my license is classified as inactive. I further understand that if I request reactivation of my license, the Board may require me to pass the SPEX and any combination of physical, psychiatric, or psychological examinations or interviews it deems necessary to determine my ability to safely engage in the practice of medicine. A.R.S. §32-1431.

☐ **I request CANCELLATION of my medical license.** I am not presently under investigation by the Board, the Board has not commenced disciplinary proceedings against me, and I am no longer practicing medicine in Arizona.

QUESTIONNAIRE

1. Since your last renewal, have you had any application for medical licensure denied or rejected by another state or province licensing board? If so provide an explanation. ☐ Yes ☑ No

2. Since your last renewal, has disciplinary or rehabilitative action been taken against you by another licensing board including other health professions. If so provide an explanation. ☐ Yes ☑ No

3. Since your last renewal, have any disciplinary actions , restrictions or limitations been taken against you while participating in any type of program or by any healthcare provider? If so provide an explanation. ☐ Yes ☑ No

4. Since your last renewal have you been found in violation of a statute, rule, or regulation of any domestic or foreign governmental agency? If so, provide an explanation. ☐ Yes ☑ No

5. Since your last renewal have you been under investigation by any medical board or peer review body? If so, provide an explanation. ☐ Yes ☑ No

6. Since your last renewal, have you had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation during an investigation or entered into a consent agreement or stipulation? If so, provide an explanation. ☐ Yes ☑ No

7. Since your last renewal, have you had hospital privileges revoked, denied, suspended, or restricted? If so, provide an explanation. ☐ Yes ☑ No

8. Since your last renewal, have you been named as a defendant in a malpractice matter currently pending or that resulted in a settlement or judgment against you? If so, provide an explanation and a copy of the complaint and either the agreed terms of settlement or the judgment. The verification must contain the name and address of each defendant, the name and address of each plaintiff, the date and location of the occurrence which created the claim and a statement specifying the nature of the occurrence resulting in the medical malpractice action. ☐ Yes ☑ No

9. Since your last renewal, have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? If so, provide an explanation. ☐ Yes ☑ No

10. Since your last renewal, have you had your authority to prescribe, dispense, or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency? If so, provide an explanation. ☐ Yes ☑ No [redacted]

11. Since your last renewal, have you engaged or do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication? If so, provide an explanation.

12. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? If so, provide an explanation. See list of Moral Turpitude items at www.azmd.gov ☐ Yes ☑ No

NOTE: In the event that the response to any of the questions above is "Yes," you must file with the renewal a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. In addition, you must submit photocopies of any corresponding documents, such as complaints or board actions.

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

First Name: SAMUEL **Initial:** [ ] **Last Name:** AUERBACH

License Number: 29924

CONFIDENTIAL QUESTIONNAIRE

[redacted]

1. Since your last renewal have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine including a diagnosis or treatment for any psychotic disorder or substance abuse disorder? If so, provide an explanation.

2. Since your last renewal, have you consumed intoxicating beverages resulting in your ability being impaired or limited to exercise the judgment and skills of a medical professional? If so, provide an explanation.

NOTE: In the event that the response to any of the questions above is "Yes," you must file with the application a detailed written narrative statement concerning the above matter(s), including the name of healthcare providers and treatment centers where you were treated, along with the discharge summary of your treatment and progress. If you are currently participating or have participated in the past 5 years, pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with compliance reports from the state monitoring programs.

Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

I ATTEST THAT ALL INFORMATION SUBMITTED ON AND WITH THIS RENEWAL APPLICATION IS TRUE. This includes information and responses provided on all four pages of the renewal application, any corrections made to the enclosed physician profile, and any information provided on or submitted with the CME Audit Form.

First Name: SAMUEL **Initial:** [ ] **Last Name:** AUERBACH

Signature: Samuel Auerbach **License Number:** 29924

Questions?

BIENNIAL MD LICENSE RENEWAL APPLICATION

(Please Type in Spaces Provided)

☑ **License Fee: $500** (If postmarked by due date)

☐ **$850** if postmarked 30 days after due date

$500/14

RECEIVED
AUG 01 2011
AZ MEDICAL BOARD

BEFORE COMPLETING THIS RENEWAL FORM: Please review your physician profile, located at www.azmd.gov. If any of the information is incorrect, please print a copy, line out the erroneous information, write in the correct information and submit it with your renewal. You are subject to discipline if you provide erroneous information. Please note that name changes must be made under separate cover.

REMEMBER: *There is a $25 fee for processing a deficient renewal. Please double check your completed application before mailing.*

First Name: SAMUEL **Initial:** **Last Name:** AUERBACH

License Number: 29924

ADDRESSES:

Office Address: This is the office/principal place of business. The address and phone number will appear in the Medical Directory and on the Board's web site. Every physician must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public. If you want your home address to be listed on your web site profile, please so indicate. Otherwise, no address will be be provided on the profile, but it will be provided to the public if requested.

Mailing Address: If no address is provided, all Board correspondence will be sent to the Office Address.

Email: This address is optional. If you provide an email address, it will not be released to the public.

Home Address: You are required to provide a home address and telephone number. They will not be released to the public *unless* you fail to provide an Office Address.

Practice Name: SAMUEL AUERBACH MD

Office Address: 1615 EAST OSBORN ROAD **City:** PHOENIX **State:** AZ **Zip:** 85016

Office Phone: 602 462 5559 **Office Fax:** 602 667 6608

Mailing Address: 1615 EAST OSBORN ROAD **City:** PHOENIX **State:** AZ **Zip:** 85016

Email:

Home Address: [redacted] **City:** [redacted] **State:** [redacted] **Zip:** [redacted]

Home Phone: [redacted] **Mobile Phone:** [redacted]

PLEASE NOTE: *You are required to notify the Board in writing within 30 days of any change in office or home address and telephone number. A.R.S. §32-1435(B) & (D). There is a fine of $100 for failure to report change of address.*

AMERICAN BOARD OF MEDICAL SPECIALTY (ABMS) CERTIFICATIONS AND FIELDS OF PRACTICE: Please review and correct the fields of practice and ABMS board certification information as shown on your profile. Only certifications from the American Board of Medical Specialties will be shown. Select the field of practice from the drop down list. If you are Board certified, check "yes." If certified since your last renewal, please attach a copy of the ABMS certificate or letter.

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
GYN/OB	☐ Yes ☑ No	☑ Yes ☐ No	
INTERNAL MEDICINE	☐ Yes ☑ No	☑ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

PROOF OF CITIZENSHIP: Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States. Federal law, 8 U.S.C. §1641 and State law, A.R.S. §1-501, require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona. Statement of Citizenship and Alien Status available on the website.

I am a U.S. Citizen or a qualified registered alien.
IF YOUR LEGAL STATUS HAS CHANGED SINCE YOUR LAST RENEWAL OR YOU HAVE A NEW DOCUMENT WITH CURRENT VALID DATES, PLEASE INCLUDE A COPY WITH YOUR RENEWAL. The Board will contact you prior to mailing of your wallet card if we do not have a copy of your legal status on file.

PROTOCOL FOR STORAGE, TRANSFER AND ACCESS OF PATIENT MEDICAL RECORDS

I am aware that it is unprofessional conduct to fail to have a written protocol in place for the secure storage, transfer and access of patient medical records when a physician terminates or sells his/her practice and the medical records do not remain in the same physical location. I have a protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close, as required by A.R.S. §32-3211.

CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

I have completed a minimum of 40 hours CME during the two previous calendar years of renewal year as required by A.R.S. §32-1434 and A.A.C. §R4-16-101.

****Please do not submit proof of CME unless you received notice on your renewal that you are subject to a CME audit. If an audit was indicated, please submit the CME documentation with your completed renewal.*

REQUEST FOR CHANGE IN LICENSE STATUS: You may request INACTIVATION or CANCELLATION of your license using this form. Do not submit a license renewal fee if you are requesting inactivation or cancellation; however, you must sign and date this form.

☐ **I request INACTIVATION of my medical license.** I am not presently under investigation by the Board, the Board has not commenced disciplinary proceedings against me, and *I am totally retired from the practice of medicine in this state or any state, territory, or district of the United States or foreign country*. I understand that once inactive status is granted, the Board will waive the annual renewal fees and requirements for CME. I understand that I may not engage in the practice of medicine, hold registration with the Drug Enforcement Administration, or write prescriptions as long as my license is classified as inactive. I further understand that if I request reactivation of my license, the Board may require me to pass the SPEX and any combination of physical, psychiatric, or psychological examinations or interviews it deems necessary to determine my ability to safely engage in the practice of medicine. A.R.S. §32-1431.

☐ **I request CANCELLATION of my medical license.** I am not presently under investigation by the Board, the Board has not commenced disciplinary proceedings against me, and I am no longer practicing medicine in Arizona.

QUESTIONNAIRE

1. Since your last renewal, have you had any application for any professional license refused or denied by any licensing authority?	☐ Yes	☑ No
2. Since your last renewal, have you been refused or denied the privilege of taking an examination required for any professional licensure?	☐ Yes	☑ No
3. Since your last renewal, have you voluntarily surrendered any healthcare license?	☐ Yes	☑ No
4. Since your last renewal, have you had any healthcare license revoked?	☐ Yes	☑ No
5. Since your last renewal, have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, license healthcare facility or healthcare staff of such facility?	☐ Yes	☑ No
6. Since your last renewal, have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	☐ Yes	☑ No
7. Since your last renewal, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? "Disciplinary Action" includes, but is not limited to restriction, termination, voluntary or involuntary resignation or withdrawn.	☐ Yes	☑ No
8. Since your last renewal, have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied, or have you surrendered or given up in lieu of action?	☐ Yes	☑ No
9. Since your last renewal, have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, or misdemeanor involving moral turpitude? (See explanation below) A "yes" answer is required even if you entered a diversion program.	☐ Yes	☑ No
10. Since your last renewal, have you been charged with or convicted (including a nolo contendre plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not the sentence was imposed or expunged?	☐ Yes	☑ No
11. Since your last renewal, have you been court martialed or discharged other than honorably from the armed service?	☐ Yes	☑ No
12. Since your last renewal, have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	☐ Yes	☑ No
13. Since your last renewal, have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	☐ Yes	☑ No

NOTE: In the event that the response to any of the questions above is "Yes," you must file with the renewal a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. In addition, you must submit photocopies of any corresponding documents, such as complaints or board actions.

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

First Name: SAMUEL **Initial:** **Last Name:** AUERBACH

License Number: 29924

CONFIDENTIAL QUESTIONNAIRE

[redacted]

1. Since your last renewal have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?

2. Are you now being treated or since your last renewal have you been treated for a drug or alcohol addiction or participated in a rehabilitation program? *If in a confidential program in another state see explanation below.

3. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice?

Ability to practice medicine is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

NOTE: In the event that the response to any of the questions above is "Yes," you must file with the application a detailed written narrative statement concerning the above matter(s), including the name of healthcare providers and treatment centers where you were treated, along with the discharge summary of your treatment and progress. If you are currently participating or have participated in the past 5 years, pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with compliance reports from the state monitoring programs.

Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

I ATTEST THAT ALL INFORMATION SUBMITTED ON AND WITH THIS RENEWAL APPLICATION IS TRUE. This includes information and responses provided on all four pages of the renewal application, any corrections made to the enclosed physician profile, and any information provided on or submitted with the CME Audit Form.

First Name:	SAMUEL	**Initial:**		**Last Name:**	AUERBACH
Signature:	Samuel Auerbach			**License Number:**	29924

Questions?

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 29924 **Renewal Fee: $500 $850** (if postmarked 30 days after due date)

Name: SAMUEL L. AUERBACH, **MD**

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER

1615 EAST OSBORN ROAD
PHOENIX, ARIZONA 85016

Phone #: 602-462-5559 **Fax #:** 602-667-6608

E-Mail: —

MAILING ADDRESS

1615 EAST OSBORN ROAD
PHOENIX ARIZONA 85016

RECEIVED
AUG 17 2009
AZ MEDICAL BOARD

HOME ADDRESS

[redacted]

Phone #: [redacted]
Mobile #:

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

Only certifications from ABMS will be shown in your profile on the website. Please indicate expiration date or lifetime certificate.

Field of Practice Code (see attached form for code)	ABMS Certified? (Y/N)	Practicing? (Y/N)	Expiration Date (or indicate lifetime certificated)
OBG	N	Y	-
IM	N	Y	-

REQUEST FOR CHANGE IN LICENSE STATUS:

☐ **INACTIVE STATUS** (I have read and meet the requirements for Inactive status as listed in the instructions)
☐ **CANCELLATION** (I have read and meet the requirements to cancel my license as listed in the instructions)

I hereby certify, under penalty of perjury by my signature below that all information on this form is currently accurate and

- I have completed a minimum of 40 credit hours of continuing medical education during the previous two calendar years of my renewal as required by A.R.S. §32-1434 and A.A.C. § R4-16-101
- I have a written protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close as required by A.R.S. §32-3211

☑ **I am a U.S. Citizen or U.S. National** (If this box is checked please submit with your application a copy of one of the listed approved supporting documents listed in the "Arizona Statement of Citizenship and Alien Status for State Public Benefits" i.e. Birth Certificate, U.S. Passport, etc.)

☐ **I am NOT a U. S. Citizen or U.S. National** (If this box is checked you must download, complete and submit with your application "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents i. e. Alien Registration Card, Visa, etc.)

Samuel L Auerbach MD — 9-25-09

Signature of Licensee (Signature stamp will not be accepted) — Date

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES ☐	NO ☑
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐	NO ☑
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES ☐	NO ☑
4. Since your last renewal have you had any healthcare license revoked?	YES ☐	NO ☑
5. Since your last renewal, have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☑
6. Since your last renewal have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☑
7. Since your last renewal, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? "Disciplinary Action" includes, but is not limited to, restriction, termination, voluntary or involuntary resignation or withdrawn.	YES ☐	NO ☑
8. Since your last renewal have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	YES ☐	NO ☑
9. Since your last renewal have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) A "yes" answer is required even if you entered a diversion program.	YES ☐	NO ☑
10. Since your last renewal have you been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES ☐	NO ☑
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	YES ☐	NO ☑
12. Since your last renewal have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐	NO ☑
13. Since your last renewal have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	YES ☐	NO ☑

Note: ***In the event the response to any of the questions numbered 1 through 13 is "YES",*** you must file with the renewal a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. IN ADDITION, you must submit photocopies of any corresponding documents, such as complaints or board actions.

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claim, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale & Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

Name: SAMUEL L. AUERBACH

License Number: 29924

Signature: Samuel L Auerbach

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

1.	**Since your last renewal have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?**
2.	**Are you now or since your last renewal been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?**
3.	**Are you now being treated or since your last renewal have you been treated or evaluated for a drug or alcohol addiction or participated in a rehabilitation program?** *If in a confidential program in another state see explanation below.
4.	**Since your last renewal have you been criminally charged with or investigated by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility for inappropriate contact with a patient or patients?**
5.	**Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice?**

Ability to practice medicine is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to chronic and/or uncorrected orthopedic, visual, speech, or hearing impairments, epilepsy, multiple sclerosis, behavioral health illness, dementia, drug addiction and alcoholism.

In the event you answer YES to any of the above questions, you must file with the renewal a detailed written narrative statement concerning the above matter(s), including the name and address of healthcare providers, physicians, preceptors, hospitals/rehabilitation centers, etc. where you were counseled/treated. You must also have a copy of your history and physical examinations, consultation reports, discharge summaries from all hospitals/rehabilitation centers and a statement from your attending physicians or treating therapists setting forth your diagnosis, prognosis and recommendations for continuing care, treatment, supervision and a statement as to whether there is anything that would prevent you from safely practicing any type of medicine. **Statement from attending physician must come with your renewal.** Treatment records must be sent directly to the board.

If you are currently participating or have participated pursuant to a CONFIDENTIAL AGREEMENT OR ORDER in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues YOU MUST SUBMIT A NARRATIVE OF CIRCUMSTANCES WITH YOUR RENEWAL AND REQUEST THE FOLLOWING DOCUMENTATION BE SENT DIRECTLY TO THE ARIZONA MEDICAL BOARD'S PHYSICIAN HEALTH PROGRAM.

• Evaluation/Treatment records • Psychiatric/Psychological records • Compliance reports from state monitoring programs

Please note: All documents requested above must be sent directly from the primary source to the Arizona Medical Board's Physician Health Program Department from the primary source and will not be accepted if submitted by the applicant.
FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.
If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

Name: SAMUEL L. AUERBACH License Number: 29924

Signature: Samuel L Auerbach

ARIZONA MEDICAL BOARD
2007 BIENNIAL MD LICENSE RENEWAL APPLICATION

Q4311

AZ MD Lic#: 29924 Samuel L. Auerbach, MD **Renewal Fee: $500 /$850** (if postmarked after **09/30/2007**)

CURRENT INFORMATION Please review and make corrections as necessary ™	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 8733 Beverly Blvd Ste 101 West Hollywood CA 90048-1841	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** 1615 EAST OSBORN PHOENIX, AZ 85016
Phone #: (805) 953-5848 **Fax #:** (718) 273-4996 **E-Mail:**	**Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS [redacted] RECEIVED AUG 0 3 2007	**MAILING ADDRESS** 1615 EAST OSBORN PHOENIX, AZ 85016
HOME ADDRESS [redacted] ONA MEDICAL BOARD BUSINESS OPERATIONS	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** **E-Mail:** **Mobile #:**	**Phone #:** **Fax #:** **E-Mail:** **Mobile #:** (Optional)

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

Only certifications from ABMS will be shown in your profile on the website. Please indicate expiration date or lifetime certificate.

	Certified?	Practicing?
OBG	N	N
IM	N	N

Make corrections if necessary INTIALS REQUIRED

	Certified?	Practicing?	Expiration Date	Initials Required
		Y		AA

If you don't verify the above fields by your initials the ABMS certification will be removed from your profile on the website.

REQUEST FOR CHANGE IN LICENSE STATUS:

- ☐ **INACTIVE STATUS** (I have read and meet the requirements for Inactive status as listed in the instructions)
- ☐ **CANCELLATION** (I have read and meet the requirements to cancel my license as listed in the instructions)

I hereby certify, under penalty of perjury by my signature below that all information on this form is currently accurate and:

- I am a U.S. Citizen or a qualified/registered alien
- I have completed a minimum of 40 credit hours of continuing medical education during calendar years 2005 and 2006 as required by A.R.S. §32-1434 and A.A.C. § R4-16-101
- I have a written protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close as required by A.R.S. §32-3211.

Samuel L Auerbach 8-1-07

Signature of Licensee (Signature stamp will not be accepted) Date

29924 Samuel L. Auerbach, MD

SEE REVERSE SIDE

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES ☐	NO ☑
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐	NO ☑
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES ☐	NO ☑
4. Since your last renewal have you had any healthcare license revoked?	YES ☐	NO ☑
5. Since your last renewal, have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☑
6. Since your last renewal have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☑
7. Since your last renewal, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? "Disciplinary Action" includes, but is not limited to, restriction, termination, voluntary or involuntary resignation or withdrawn.	YES ☐	NO ☑
8. Since your last renewal have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	YES ☐	NO ☑
9. Since your last renewal have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) A "yes" answer is required even if you entered a diversion program.	YES ☐	NO ☑
10. Since your last renewal have you been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES ☐	NO ☑
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	YES ☐	NO ☑
12. Since your last renewal have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐	NO ☑
13. Since your last renewal have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	YES ☐	NO ☑

Note: ***In the event the response to any of the questions numbered 1 through 13 is "YES",*** you must file with the renewal a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. IN ADDITION, you must submit photocopies of any corresponding documents, such as complaints or board actions.

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claim, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale & Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

29924 Samuel L. Auerbach, MD **INITIALS REQUIRED** SLA

1.	**Since your last renewal have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?**	[redacted]
2.	**Are you now or since your last renewal been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?**	
3.	**Are you now being treated or since your last renewal have you been treated or evaluated for a drug or alcohol addiction or participated in a rehabilitation program?** *If in a confidential program in another state see explanation below.	
4.	**Since your last renewal have you been criminally charged with or investigated by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility for inappropriate contact with a patient or patients?**	
5.	**Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice?** **Ability to practice medicine is to be construed to include all of the following:** 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments; 2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and 3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids. "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to chronic and/or uncorrected orthopedic, visual, speech, or hearing impairments, epilepsy, multiple sclerosis, behavioral health illness, dementia, drug addiction and alcoholism.	

In the event you answer YES to any of the above questions, you must file with the renewal a detailed written narrative statement concerning the above matter(s), including the name and address of healthcare providers, physicians, preceptors, hospitals/rehabilitation centers, etc. where you were counseled/treated. You must also have a copy of your history and physical examinations, consultation reports, discharge summaries from all hospitals/rehabilitation centers and a statement from your attending physicians or treating therapists setting forth your diagnosis, prognosis and recommendations for continuing care, treatment, supervision and a statement as to whether there is anything that would prevent you from safely practicing any type of medicine. **Statement from attending physician must come with your renewal.** Treatment records must be sent directly to the board.

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• Evaluation/Treatment records • Psychiatric/Psychological records • Compliance reports from state monitoring programs

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FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.
If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

29924 Samuel L. Auerbach, MD **INITIALS REQUIRED** _____

ARIZONA MEDICAL BOARD
2005 BIENNIAL MD LICENSE RENEWAL APPLICATION

9007

AZ MD Lic#: 29924 Samuel L. Auerbach, MD **Renewal Fee: $500** **$850** (if postmarked after 09/30/2005)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 1037 W Avenue N Palmdale CA 93551-2002	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** 8733 BEVERLY BLVD SUITE #101 LOS ANGELES, CA 90048
Phone #: (818) 609-9070 **Fax #:** **E-Mail:**	**Phone #:** 805-953-5848 **Fax #:** 718-273-4996 **E-Mail:**
MAILING ADDRESS [redacted]	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** **E-Mail:**	**Phone #:** [redacted] **Fax #:** [redacted] **E-Mail:** **Cell Phone #:** (Optional)

RECEIVED JUL 28 2005 By

AMERICAN BOARD CERTIFICATIONS AND FIELDS OF PRACTICE: *Select from the attached list of Self-Designated "Field of Practice" Codes*

	Certified?	Practicing?
OBG	N	N
IM	N	N

Make corrections if necessary

	Certified?	Practicing?

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

☐ **INACTIVE STATUS**: Please inactivate my Arizona license. My signature below serves to certify the following: That I am not presently under investigation by the board, the board has not commenced any disciplinary proceedings against me, and I am totally retired from the practice of medicine in this state or any state, territory, or district of the United States or foreign country. I understand that once inactive status is granted, the board will waive the annual renewal fees and requirements for CME. I further understand that I may not engage in the practice of medicine, hold registration with the Drug Enforcement Administration, or write prescriptions as long as my license is classified as inactive. I further understand that if I request reactivation of my license, I may be required to pass the SPEX examination and that the board may require any combination of physical examination, psychiatric, psychological evaluations and interviews it deems necessary to determine my ability to safely engage in the practice of medicine.

☐ **CANCELLATION**: Please cancel my Arizona license. My signature below serves to certify the following: That I am not presently under investigation by the board; the board has not commenced any disciplinary proceedings against me; and that I am requesting cancellation for the reason that I am no longer practicing medicine in the State of Arizona.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Other than in Arizona, are you currently under investigation by any medical board or peer review body? ☐ Yes ☑ No
2. Other than in Arizona, since your last renewal have you had a medical license disciplined resulting in revocation, suspension, limitation, restriction, probation, voluntary surrender or cancellation during an investigation? **(see instructions on back)** ☐ Yes ☑ No
3. Since your last renewal have you had hospital privileges revoked, denied, suspended or restricted? **(see instructions)** ☐ Yes ☑ No
4. Since your last renewal, have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? **(see instructions)** ☐ Yes ☑ No
5. Since your last renewal, have you had the authority to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered or revoked by a federal or state agency? **(see instructions)** ☐ Yes ☑ No
6. Within the last 5 years, have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine? **(see instructions)** [redacted]
7. Do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication? [redacted]
8. Have you consumed intoxicating beverages resulting in your present ability to exercise the judgment and skills of a medical professional, being impaired or limited? [redacted]
9. Have you been denied a license in another state? If yes, ☐ Yes ☑ No
   State_____ Date of Denial_____ Reason for Denial_____
10. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? ☐ Yes ☑ No
    If yes, please attach an explanation and applicable court docket. See instructions on back.
11. Since your last renewal, has a malpractice lawsuit resulted in a settlement or judgment against you? ☐ Yes ☑ No

If the answer is "yes" to any of the above questions, please provide a complete written explanation to include dates. If malpractice cases are reported, please include: a copy of the complaint and settlement agreement/judgment.

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2003 and 2004, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

Samuel L Auerbach MD
Signature of Licensee (Signature stamp will not be accepted)

7/28/05
Date

NOTE: DO NOT SUBMIT CME DOCUMENTATION UNLESS A CME AUDIT FORM IS INCLUDED WITH YOUR RENEWAL PACKET

ARIZONA MEDICAL BOARD
2003 BIENNIAL MD LICENSE RENEWAL APPLICATION

0190

AZ MD Lic#: 29924 Samuel L. Auerbach, MD **Renewal Fee: $500** **$850** (if postmarked after 09/30/2003)

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MAILING ADDRESS [redacted]	**MAILING ADDRESS** [redacted]
HOME ADDRESS [redacted] **Phone #:** [redacted] **Fax #:** **E-Mail:**	**HOME ADDRESS** **Phone #:** **Fax #:** **E-Mail:** **Cell Phone #:** (Optional)

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Make corrections if necessary

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I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2001 and 2002, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

Samuel L. Auerbach — 8/1/03

Signature of Licensee (Signature stamp will not be accepted) Date

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