CC

$500

APPLICATION

Official Use Only: Inquiry # 41803 **Date Application Received** _____

(To be completed and signed by applicant. All questions MUST be answered, even if only to indicate "None" or "N/A".)

1. Present Name TAYLOR (Last) DESHAUN (First) LAKISHA (Middle) _____ (Maiden)

   (a) Other names used: DESHAUN TAYLOR-HARRIS

2. Office/Training Address: 1240 N. STATE ST., INPATIENT TOWER, 3C OB/GYN, LOS ANGELES, CA 90033
   (No.) (Street) (City) (State) (Zip/Post Code)

3. All States or provinces in which you **have or had** a license or registration. If more than five, attach separate listing. If license is pending or was not issued, so state. If none, please indicate by stating "Not Applicable."

   (a) CALIFORNIA A83243 ACTIVE
   (State Board) (License No.)(Status of License, i.e., expired, active, etc.)

   (b) _____
   (State Board) (License No.)(Status of License, i.e., expired, active, etc.)

   (c) _____
   (State Board) (License No.)(Status of License, i.e., expired, active, etc.)

   (d) _____
   (State Board) (License No.)(Status of License, i.e., expired, active, etc.)

   (e) _____
   (State Board) (License No.)(Status of License, i.e., expired, active, etc.)

4. Medical School Name: CHARLES DREW/UCLA MEDICAL EDUCATION PROGRAM

   Medical School Location: LOS ANGELES, CA Date of Graduation: 6/2/2001
   Month/Day/Year

   If you graduated from a medical school located outside the United States of America or Canada please list below:

   ECFMG # _____ Certificate Date: _____
   Month/Day/Year

5. List chronologically, all Internship, Residency and Fellowship training in U.S. or Canada **(COMPLETED OR NOT)**, or Assistant Professorship (or higher) at any programs attended, showing institution, address, type of program and dates. Attach separate listing if needed.

INSTITUTION NAME	CITY/STATE	TYPE OF PROGRAM/PGY YEAR	DATES OF ATTENDANCE
KING/DREW MEDICAL CENTER	LA/CA	PGY 1-4	7/2001 - 6/2005
UNIVERSITY OF SOUTHERN CALIFORNIA	LA/CA	FAMILY PLANNING FELLOWSHIP	7/2005 - 6/2007

FEB 25

6. License Exam: Please indicate all exams taken, the date(s) taken (month/day/year) and what state, if applicable:

   a. United States Medical Licensing Exam (USMLE)
   1999 (Step I (Date)) 2000 (Step II (Date)) 2002 (Step III (Date)) CA (State)
   b. State Written Examination Date _____ State _____
   (The Commonwealth of Puerto Rico written examination is not accepted)
   c. National Board of Medical Examiners Examination (NBME) Certification Date _____
   d. Federation of State Medical Boards Licensing Examination (FLEX) Date(s) _____ (Comp I (Date)) _____ (Comp II (Date))
   e. Licentiate of the Medical Council of Canada (LMCC) Date _____
   f. Special Purpose Examination (SPEX) Date _____ State _____

7. Indicate your area of practice: OBSTETRICS AND GYNECOLOGY

8. List all certifications and re-certifications by a board or sub-board recognized by the **American Board of Medical Specialties only.**

Specialty Board	Certification #	Dates of Certification/Recertification	Expiration Date

9. Account for, in **chronological order**, all activities since graduation from medical school to present. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. Attach a separate sheet if necessary. DO NOT ATTACH A CURRICULUM VITA (CV).**

ACTIVITIES	LOCATION	FROM/TO (MONTH/YEAR)
(eg. Prepare for USMLE Examination)	(City, State)	(eg. 06/99 to 01/00)
OB/GYN RESIDENCY	LA/CA	07/01 - 06/05
FAMILY PLANNING FELLOWSHIP	LA/CA	7/05 - 6/07
USC CLINICAL SCHOOL	LA/CA	8/05 - 6/07
OB/GYN PHYSICIAN FACULTY	LA/CA	7/05 - PRESENT

Applicant Name DESHAWN TAYLOR, M.D. (2)

10. Have you ever had any application for any professional license refused or denied by any licensing authority?	YES ☐	NO ☒
11. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐	NO ☒
12. Have you ever been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled?	YES ☐	NO ☒
13. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently?	YES ☐	NO ☒
14. Have you ever voluntarily surrendered any healthcare license?	YES ☐	NO ☒
15. Have you ever had any healthcare license revoked?	YES ☐	NO ☒
16. Have you ever been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☒
17. Have your privileges ever 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 ☒
18. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.	YES ☐	NO ☒
19. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?.	YES ☐	NO ☒
20. Have you ever 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 ☒
21. Have you ever 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 ☒
22. Have you ever 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 ☒
23. In the last ten (10) years has a judgment or settlement been entered against you as a defendant in a medical malpractice suit? *Please do not report pending malpractice suits or settlements paid not related to a civil action.	YES ☐	NO ☒
24. Have you ever been court martialed or discharged other than honorably from the armed service?	YES ☐	NO ☒
25. Have you ever been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐	NO ☒
26. Have you ever 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 10 through 26 is "YES"***, **the applicant must 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). IN ADDITION, the applicant must submit photocopies of any complaints, hearings, settlements or judgments together with copies of patient's hospital and/or office records to the AMB.**

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.

Applicant Name Dr. Sriram Taylor, M.D. (3)

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

1. 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]
2. Are you now or have you in the last 5 years been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?	
3. Are you now being treated or have you in the last 5 years 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. Have you ever 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? **See below for definition of ability to practice medicine.**	

In the event you answer YES to any of the above questions, **you must file with the application a detailed written narrative statement concerning the above matter(s), including the name and address of all training programs or 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. This must be sent directly to the AMB.**

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 APPLICATION 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, INCLUDING REVOCATION OR DENIAL OF A LICENSE.

If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

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.

Applicant Name DeShawn Taylor, M.D. (4)

The applicant DESHAWN TAYLOR, M.D.
(PRINT OR TYPE YOUR NAME)

being first duly sworn upon his oath deposes and says: that I am the person herein named subscribing to this application; that I have read the statutes and rules regarding licensure and have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am 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 Medical Board 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 Medical Board 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.

Under penalty of perjury I certify I am a U.S. Citizen or a qualified/registered alien.

Signature of Applicant _____, **M.D.** **Date** 2/22/09

If you would like to designate/authorize ONE other individual beside yourself to check the status of your application with the AMB, please complete the following information:

Entity name:_____ Individual Name_____ Phone #_____

*** ARIZONA LAW REQUIRES AN APPLICANT WHO HAS BEEN CHARGED WITH A FELONY OR A MISDEMEANOR INVOLVING CONDUCT THAT MAY AFFECT PATIENT SAFETY AFTER SUBMITTING THE APPLICATION TO NOTIFY THE AMB WITHIN 10 DAYS AFTER THE CHARGE IS FILED. ARIZONA REVISED STATUTE (A.R.S.) §32-3208 (SEE WEBSITE UNDER *Physician Center – Reportable Misdemeanors* FOR LIST OF REPORTABLE MISDEMEANORS – ALL FELONIES ARE REPORTABLE.)**

FOR OFFICIAL USE ONLY

Application Processed by USCIS 3/19/09

Application Approved 4/7 2009 by Suzann Grabe

License Issued 4/30/09 License Number 41803

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700Fax: 480-551-2704
www.azmd.gov

MAR 04 2009

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 **Dean or the Registrar** of all medical schools attended. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax. Your prompt response will be appreciated.

Applicant Name: DeShawn Taylor (Taylor-Harris) M.D.

Signature Date (Month/Day/Year) 2/25/09

(DO NOT DETACH)

This section to be completed by an official of the Medical school.

This certifies that DeShawn LaKisha Taylor-Harris
(Name of applicant)

was enrolled in David Geffen School of Medicine at UCLA Los Angeles, CA
(Name of Medical School) (Location – City/State)

The undersigned further certifies that the records of this institution show that the applicant attended this institution

from 08/1997 (month/year) to 06/2001 (month/year)

Please check one: ✓ The applicant was granted a medical degree by

_____ The applicant withdrew from

the above named Medical School on 06/01/2001 (month /day /year).

Advanced credits – Credits granted upon admission

(name of medical school)	(total credits)	(dates attended)
N/A		

(SEAL OF COLLEGE)

(If no seal, please indicate)

Signed: Martin Hunter

Name Typed or Printed: Martin Hunter

Title: Registrar Date 02/27/2009

Address: 12-159 CHS, Box 951720, Los Angeles, CA 90095

Telephone number: 310-825-6282 Fax number: 310-794-9574

VERIFIED
Licensing

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700Fax: 480-551-2704
www.azmd.gov

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 the **Program Director** of each postgraduate training program in the United States, its territories, and/or Canada that I participated in. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax. Your prompt response will be appreciated.

Applicant Name: DeShawn Taylor, M.D.

Signature: [signature] Date (Month/Day/Year): 2/22/09

(DO NOT DETACH)

Important – Program Participation: Report incomplete postgraduate years (PGY) separately from those that were successfully completed. If the postgraduate year is currently in progress, report the expected completion in the "To" field. Report internships, residencies and fellowships separately.

PG/Year: I DEPARTMENT/SPECIALTY: OBSTETRICS & GYNECOLOGY
✓ Internship
___ Residency From: 07 / 01 / 2001 To: 06 / 30 / 2002
___ Fellowship
___ Research Successfully completed? ✓ Yes ___ No ___ In Progress

PG/Year: II-IV DEPARTMENT/SPECIALTY: OBSTETRICS & GYNECOLOGY
___ Internship
___ Residency From: 07 / 01 / 2002 To: 06 / 30 / 2005
___ Fellowship
___ Research Successfully completed? ✓ Yes ___ No ___ In Progress

PG/Year: ___ DEPARTMENT/SPECIALTY: ___
___ Internship
___ Residency From: __/__/__ To: __/__/__
___ Fellowship
___ Research Successfully completed? ___ Yes ___ No ___ In Progress

Circle the correct response to the question below:
This program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education (ACGME), or the Royal College of Physicians and Surgeons of Canada. (Yes) No

Circle the correct response to the questions below: ("Yes" responses require written explanation.)
Did this individual ever take a leave of absence or break from their training? Yes (No)

Was this individual disciplined and/or placed under investigation or on probation? Yes (No)

Please explain below any "Yes" responses(s) to the above two questions. If necessary, you may continue your explanation on a separate sheet of paper.

* Verification based solely on File Review.

Signed: [signature] (SEAL OF TRAINING PROGRAM)

Name Typed or Printed: Nancy Hannaman (If no seal, please indicate)

Title: ___ Date: 2-4-09

Full name of Hospital or Program: Martin Luther King Jr. Drew Medical Center

Address: 12021 S. Wilmington Ave. Los Angeles, CA 90059

Telephone number: 323.563.9373 Fax number: 310.563.5918

2/25 02-23-09 07 VERIFIED Postgrad licensing

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700Fax: 480-551-2704
www.azmd.gov

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 the Program Director of each postgraduate training program in the United States, its territories, and/or Canada that I participated in. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax. Your prompt response will be appreciated.

Applicant Name: DESHAWN TAYLOR, M.D.

Signature: [signature] Date (Month/Day/Year): 3-20-09

(DO NOT DETACH)

Important – Program Participation: Report incomplete postgraduate years (PGY) separately from those that were successfully completed. If the postgraduate year is currently in progress, report the expected completion in the "To" field. Report internships, residencies and fellowships separately.

PG/Year: 5 DEPARTMENT/SPECIALTY: OB/GYN - FAMILY PLANNING
___ Internship ___ Residency From: 7/1/05 To: 6/30/06
X Fellowship ___ Research Successfully completed? X Yes ___ No ___ In Program

PG/Year: 6 DEPARTMENT/SPECIALTY: OB/GYN - FAMILY PLANNING
___ Internship ___ Residency From: 7/1/06 To: 6/30/07
X Fellowship ___ Research Successfully completed? X Yes ___ No ___ In Progress

PG/Year: ___ DEPARTMENT/SPECIALTY: ___
___ Internship ___ Residency From: ___/___/___ To: ___/___/___
___ Fellowship ___ Research Successfully completed? ___ Yes ___ No ___ In Progress

Circle the correct response to the question below:
This program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education (ACGME), or the Royal College of Physicians and Surgeons of Canada. (Yes) No

Circle the correct response to the questions below: ("Yes" responses require written explanation.)
Did this individual ever take a leave of absence or break from their training? Yes (No)

Was this individual disciplined and/or placed under investigation or on probation? Yes (No)

Please explain below any "Yes" responses(s) to the above two questions. If necessary, you may continue your explanation on a separate sheet of paper.

Signed: [signature] No seal (SEAL OF TRAINING PROGRAM) (If no seal, please indicate)

Name Typed or Printed: DANIEL P MISHELL JR Date 3/20/08

Title: Professor Dept Ob&Gyn

Full name of Hospital or Program: LAC+USC Medical Center

Address: 1240 North Mission Rd Rm L-1022

Telephone number: 323 226 3377 Fax number: 323 226 3429

USMLE
United States
Medical
Licensing
Examination™

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date : 02/23/2009

Recipient:

Arizona Medical Board
ATTN: Lisa S Wynn, Executive Director
9545 E Doubletree Ranch Road
Scottsdale, AZ 85258

Examinee ID#: 5-066-123-0
Date of Birth: [redacted]

Examinee: Taylor, DeShawn
Alt Name(s): Taylor, Deshawn Lakisha
Taylor-Harris, Deshawn Lakisha

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/11/1999	Pass	208	179	84	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	09/07/2000	Pass	209	174	84	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
CALIFORNIA	11/04/2002	Pass	196	182	80	75	
CALIFORNIA	06/10/2002	Fail	181	182	74	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov • E-Mail: questions@azmd.gov

March 19, 2009

DeShawn Lakisha Taylor M.D.
1701 S. Atlantic Blvd.
Unit K
Alhambra, CA 91803

Dear Dr. Taylor:

This will acknowledge receipt of your application for MD License in the State of Arizona.

I have reviewed your application and determined that the following items are still outstanding. To complete the processing of your application, the following documentation is still required.

- **Medical College Certification from:**
- **Postgraduate Training Verification from:**
  - **a. USC MEDICAL CENTER for the period of 07/01/2005 to 06/30/2007**
- **Exam Scores:**
- **Hospital Affiliation Verfication from:**
  - **a. King Drew Medical Center**
  - **b. LAC USC Womens and Childrens Hospital**
- **Medical Employment Verfication from:**

Please be advised that 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.

Futher, 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.

Should your application be approved, you will be notified of the initial licensing fee due for issuance of your license.
If you have any questions, please contact Linda Scorzo at linda.scorzo@azmd.gov or .

Sincerely,

Suzann Grabe
Licensing Office Manager

S

Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480-551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov • E-Mail: questions@azmd.gov

RECEIVED

APR 30 2009

AZ MEDICAL BOARD

April 7, 2009

DeShawn Lakisha Taylor, M.D.
[redacted]

Dear Dr. DeShawn Lakisha Taylor,

The Arizona Medical Board is pleased to inform you that your application for licensure in the State of Arizona is administratively complete and 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 on** [redacted]

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 $437.50.** This fee is your licensing fee and is in addition to the $500.00 application processing fee that you have already paid.

Please complete the bottom portion of this letter and return the completed form with the initial license registration fee payable to the Arizona Medical Board, 9545 E. Doubletree Ranch Rd., Scottsdale, AZ 85258. If paying by credit card, the completed form along with the payment card authorization must be returned. 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. **Allow up to 5 business days for the processing of your payment and issuance of your license. Please do not call and request status, as this will slow down the process.**

Registration forms and initial license fees not returned **postmarked within thirty-five days** of this notice will result in the application being withdrawn and applicant will be required to reapply.

If you have any questions, please contact me by e-mail at sgrabe@azmd.gov or by telephone at (480) 551-2756.

Sincerely,

Suzann Grabe
Licensing Office Manager

(DO NOT DETACH)

Name: DESHAWN TAYLOR, M.D.
Current Office Address: 1240 N. MISSION RD. LIDSA, LOS ANGELES, CA 90033
Current Home Address: [redacted]
Current Mailing Address: SAME AS HOME
Current Office Telephone 323-226-4978 Current Home Telephone [redacted]
Current Office E-Mail [redacted] Current Home E-Mail [redacted]
Area of Interest: OB/GYN Practicing: ☒ Yes ☐ No

NOTE: Statutes require you to provide the Board with written notification within thirty days (30) of any changes in addresses or phone numbers.

#41803
4/30/09

CK 1124
$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 18 2014
AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: DeShawn Lakisha Taylor, MD

MD LICENSE #: 41803 SPECIALTY: OB/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

1526 W Glendale Ave. Ste 109
Phoenix, AZ 85021

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

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

Physician's Signature: [signature] Date: 6/16/14

ENTERED

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2014	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	11-04-2011

TAYLOR, DESHAWN L MD
1526 W. GLENDALE AVENUE
SUITE 109
PHOENIX, AZ 85021

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

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

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND 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]	11-30-2014	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	11-04-2011

TAYLOR, DESHAWN L MD
1526 W. GLENDALE AVENUE
SUITE 109
PHOENIX, AZ 85021

Sections 304 and 1008 (21 U.S.C. 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, BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (05/04)

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2707
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: DeShawn Taylor, MD

LICENSE #: 41803 SPECIALTY: Ob/Gyn

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]

Street Address				City/State/Zip Code			
1526 W. Glendale Avenue, Ste 109				Phoenix, AZ 85021			
Phone Number				**Fax Number**		**E Mail**	
480-447-8857				480-718-8411		[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 2nd page of this form and place a check mark here: ☐

Physician's Signature: [signature] Date: 8/8/13

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, MasterCard or American Express

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

ENTERED

FAX COVER SHEET

TO	
COMPANY	
FAX NUMBER	14805512707
FROM	Desert Star Family Planning, LLC
DATE	2013-08-08 16:25:56 GMT
RE	Initial Dispensing Application - D. Taylor 41803

COVER MESSAGE

Please confirm receipt at [redacted] Thank you!

DeShawn Taylor, MD

Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2705
Website: www.azmd.gov

August 12, 2013

RE: NOTICE OF DEFICIENCY DISPENSING RENEWAL

Dear Dr. Taylor,

Please be advised that the Arizona Medical Board has received your application for a dispensing registration for fiscal year 2013-2014. Unfortunately, your renewal application is not administratively complete and we cannot issue your registration until the following items have been included and/or appropriately completed:

Need current DEA card for the following location:

1526 W Glendale Ave, Ste 109
Phoenix, AZ 85021

Please remedy one or all of the above stated deficiencies and return all of the required information to the Board at an address listed above.

In accordance to *11 A.A.R 2944*, you have 30 days from the date listed above to provide proper documentation. At that time if no documentation is provided and should you desire to pursue dispensing licensure in Arizona; a new licensure application must be filed with the Arizona Medical Board. In addition, all fees are forfeited.

If you have questions, please feel free to contact the Arizona Medical Board Licensing Department with the contact information above.

Sincerely

Arizona Medical Board

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2014	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	11-04-2011

TAYLOR, DESHAWN L MD
1526 W. GLENDALE AVENUE
SUITE 109
PHOENIX, AZ 85021

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

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

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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]	11-30-2014	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	11-04-2011

TAYLOR, DESHAWN L MD
1526 W. GLENDALE AVENUE
SUITE 109
PHOENIX, AZ 85021

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Form DEA-223 (05/04)

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2707
Home Page: http://www.azmd.gov

LC $200

RECEIVED
NOV 13 2012
AZ MEDICAL BOARD

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: DESHAUN TAYLOR, M.D.

LICENSE #: 41803 SPECIALTY: OB/GYN

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]

Street Address				City/State/Zip Code			
1331 N. 7TH STREET STE 225				PHOENIX, AZ 85006			
Phone Number				**Fax Number**		**E Mail**	
602-553-0440				602-462-5588		[redacted]	
Schedule II Drugs	X	Schedule III Drugs	X	Prescription-Only Drugs	X	Nubain	X
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices	X		

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 2nd page of this form and place a check mark here: ☐

Physician's Signature: [signature] Date: 11/12/12

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, MasterCard or American Express

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

ENTERED

TAYLOR, DESHAWN L MD

[redacted]

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2014	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	11-04-2011

TAYLOR, DESHAWN L MD
FAMILY PLANNING ASSOCIATES MEDICAL GROUP
1331 N. 7TH STREET
STE 225
PHOENIX, AZ 85006-0000

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]	11-30-2014	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	11-04-2011

TAYLOR, DESHAWN L MD
FAMILY PLANNING ASSOCIATES MEDICAL GROUP
1331 N. 7TH STREET
STE 225
PHOENIX, AZ 85006-0000

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Form DEA-223 (4/07)

faxZERO

Send a fax for free

Recipient Information

To: Arizona Medical Board
Fax #: 4805512707

Sender Information

From: DeShawn Taylor, MD
Email address: [redacted] **(from 70.199.201.140)**
Sent on: Monday, November 12 2012 at 6:07 PM EST

Date: 11/12/12

To: Arizona Medical Board

From: DeShawn Taylor, MD

RE: Dispensing renewal for DeShawn Taylor, MD, AZ license # 41803

Thank you!

DeShawn Taylor, MD

CC #158

ARIZONA MEDICAL BOARD

9546 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2704
Website: www.azmd.gov

RECEIVED
JUN 30 2011
AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: DeShawn Lakisha Taylor, MD

MD LICENSE #: 41803 SPECIALTY: OB/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

2255 N Wyatt Dr
Tucson, AZ 85712

Schedule II Drugs
Schedule III Drugs
Schedule IV Drugs
Schedule V Drugs

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

5771 W Eugie
Glendale, AZ 85304

Schedule II Drugs
Schedule III Drugs
Schedule IV Drugs
Schedule V Drugs

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

1250 E Apache #108
Tempe, AZ 85281

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

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

Physician's Signature: [signature] Date: 6/29/11

ENTERED

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2012	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	11-25-2009

TAYLOR, DESHAWN L MD
PLANNED PARENTHOOD ARIZONA
2255 N. WYATT DRIVE
TUCSON, AZ 85712

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

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UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2012	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	11-25-2009

TAYLOR, DESHAWN L MD
PLANNED PARENTHOOD ARIZONA
2255 N. WYATT DRIVE
TUCSON, AZ 85712

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Form DEA-223 (05/04)

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2011	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	06-30-2009

TAYLOR, DESHAWN L MD
PLANNED PARENTHOOD ARIZONA
5771 W EUGIE
GLENDALE, AZ 85034

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

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CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
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DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

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[redacted]	11-30-2011	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	06-30-2009

TAYLOR, DESHAWN L MD
PLANNED PARENTHOOD ARIZONA
5771 W EUGIE
GLENDALE, AZ 85034

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DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2012	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	11-06-2009

TAYLOR, DESHAWN L MD
PLANNED PARENTHOOD ARIZONA
1250 E. APACHE ROAD #108
TEMPE, AZ 85281

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

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DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2012	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	11-06-2009

TAYLOR, DESHAWN L MD
PLANNED PARENTHOOD ARIZONA
1250 E. APACHE ROAD #108
TEMPE, AZ 85281

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Form DEA-223 (05/04)

Planned Parenthood® Arizona

FAX TRANSMITTAL

Date: 6/29/11 Fax No.: 480-551-2704

To: AZ MED BD No. of pages: 6 (including cover)

From: Phone No.:

☑ DeShawn Taylor, M.D.	602.263.4236	Fax	602-604-0159
☐ Carol Bafaloukos	602.263.2231		
☐ Cynthia K. Locke	602.263.2237		
☐ Jennifer Murdaugh	602.200.2195		

Comments:

PLEASE CONFIRM RECEIPT AT NUMBER ABOVE OR [redacted]

THANK YOU VERY MUCH!

RECE... AZ MEDICA...

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2791 . Fax (480) 551-2704
Home Page http://www.azmd.gov

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: DeShawn Lakisha Taylor, MD

MD LICENSE #: 41803 SPECIALTY: OB/GYN

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.

√ 1250 E Apache #108
Tempe, AZ 85281

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

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

4417 N 7th Ave
Phoenix, AZ 85013

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

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

Physician's Signature: [signature] Date: 6/23/10

PHYSICIAN NAME: DeShawn Lakisha Taylor, MD

MD LICENSE # 41003

ADDITIONAL PRACTICE LOCATION: ✓ DEA # FOR THIS LOCATION:

Street Address				City/State/Zip Code			
5771 EUGIE				GLENDALE, AZ, 85304			
Phone Number				Fax Number		[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			
2255 N. WYATT DRIVE				TUCSON, AZ, 85712			
Phone Number				Fax Number		[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			

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			

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2012	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	PRACTITIONER	11-06-2009

TAYLOR, DESHAWN L MD
PLANNED PARENTHOOD ARIZONA
1250 E. APACHE ROAD #108
TEMPE, AZ 85281-0000

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

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Form DEA-223/511 (4/07)

REPORT

CHANGES

PROMPTLY

REQUESTING MODIFICATIONS TO YOUR REGISTRATION CERTIFICATE

To request a change to your registered name, address, the drug schedule or the drug codes you handle, please

1. visit our web site at deadiversion.usdoj.gov - or
2. call our customer Service Center at 1-(800) 882-9539 - or
3. submit your change(s) in writing to:

Drug Enforcement Administration
P.O. Box 28083
Washington, DC 20083

See Title 21 Code of Federal Regulations, Section 1301.51 for complete instructions.

You have been registered to handle the following chemical/drug codes:

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2011	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	06-30-2009

TAYLOR, DESHAWN L MD
PLANNED PARENTHOOD ARIZONA
5771 EUGIE
GLENDALE, AZ 85034

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

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UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2011	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	06-30-2009

TAYLOR, DESHAWN L MD
PLANNED PARENTHOOD ARIZONA
5771 EUGIE
GLENDALE, AZ 85034

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Form DEA-223 (06/04)

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	11-30-2012	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	11-25-2009

TAYLOR, DESHAWN L MD
PLANNED PARENTHOOD ARIZONA
2255 N. WYATT DRIVE
TUCSON, AZ 85712-0000

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

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Form DEA-223/511 (4/07)

REPORT CHANGES PROMPTLY

REQUESTING MODIFICATIONS TO YOUR REGISTRATION CERTIFICATE

To request a change to your registered name, address, the drug schedule or the drug codes you handle, please

1. visit our web site at deadiversion.usdoj.gov - or
2. call our customer Service Center at 1-(800) 882-9539 - or
3. submit your change(s) in writing to:

Drug Enforcement Administration
P.O. Box 28083
Washington, DC 20083

See Title 21 Code of Federal Regulations, Section 1301.51 for complete instructions

You have been registered to handle the following chemical/drug codes:

RECEIVED CC
JUL 15 2009 $200
ARIZONA 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 INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: DESHAWN TAYLOR, M.D.

LICENSE #: 41803 SPECIALTY: OB/GYN

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] 11/30/11

Street Address				City/State/Zip Code			
4417 N. 7TH AVE				PHOENIX, AZ. 85013			
Phone Number				Fax Number			
602-889-6574				602-889-6571		[redacted]	
Schedule II Drugs	X	Schedule III Drugs	X	Prescription-Only Drugs	X	Nubain	
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices	X		

ADDITIONAL PRACTICE LOCATION: DEA # FOR THIS LOCATION: [redacted] 11/30/09

Street Address				City/State/Zip Code			
1250 E. APACHE #108				TEMPE, AZ 85281			
Phone Number				Fax Number		E Mail	
480-966-4728				480-921-8712		[redacted]	
Schedule II Drugs	X	Schedule III Drugs	X	Prescription-Only Drugs	X	Nubain	
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices	X		

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

Physician's Signature: [signature] Date: 7/13/09

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

ENTERED

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:** 9/1/09

PRACTICE: PLANNED PARENTHOOD ARIZONA (Company Name) (If you do not have a practice address or name write the word "NONE")

Street Address Only: 5651 N. 7TH STREET
(list P.O. Box as Mailing Address below)*

City: PHOENIX **State:** AZ **Zip:** 85014-2520

Office Telephone: (602-263-4235 **Office Fax:** (602-263-4281

Office E-Mail: [redacted]

RESIDENCE ADDRESS: [redacted]

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

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

Residence E-Mail: [redacted]

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 ☐

DESHAWN TAYLOR
Name (Please print)

41803
AZ License #

Signature

9/1/09
Today's Date