APPLICATION

Official Use Only: **Inquiry #** _____ **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 FRISCH (Last) Melvin (First) Julius (Middle) _____ (Maiden)

   (a) Other names used: _____

2. Office/Training Address: 825 So. 8th (No.) ST (Street) #1018 (City) Mpls. (State) MN. (Zip/Post Code) 55403

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) MINNESOTA (State Board) 17719 (License No.)(Status of License, i.e., expired, active, etc.) Active 7/3/1967.

   (b) MONTANA (State Board) ? (License No.)(Status of License, i.e., expired, active, etc.) Expired (From 1967-1973)

   (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: UNIVERSITY of MINNESOTA Medical School

   Medical School Location: MINNEAPOLIS, MINNESOTA Date of Graduation: June 11th 1966 (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
Los Angeles Co Harbor Gen Hosp	Torrance, Ca.	Rotating Internship	(6/24/66 - 6/22/67) 6/66-6/67
Univ. of Mn. OB/GYN Residency	Minneapolis, MN.	OB/GYN	7/1/1972 - 6/30/1975
Univ. of Minn, Dept of OB/GYN Hennepin Co. Med. Center	Assistant Professor in OB GYN		1991 - 2004

NOV 14

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)

Step I (Date)	Step II (Date)	Step III (Date)	State

b. State Written Examination ~~Date~~ 6/14-16/1966 State MINNESOTA BASIC Sciences 6/3/1964
MINNESOTA clinical exam (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: No longer doing Obstetrics, presently office Gynecology with specialty in Menopause MANAGEMENT

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
AM. Board of OB/GYN		Nov. 11, 1977	GRANDFATHERED
Fellow of AM. College of OB/GYN		March 31, 1979	NO Expiration date
North AM. Menopause Society		Practioner Competency Exam	5/8/2007

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)
(e.g.) Prepare for USMLE/Vacation	City/State	06/99 to 01/00
Medical school GRADUATION	Mpls. MN	6/1966
Internship Harbor Gen. Hosp.	TORRANCE, CA.	6/1966 — 6/1967
U.S Public Health Service Division of Indian Health	Poplar, Montana	7/1967 — 6/1969
Private Medical Practice (General Practice)	Wolf Point, Montana	7/1969 — 6/1972
Univ. of MN. OB/GYN Residency	Mpls. MN	7/1972 → 6/1975
Private Practice Single OB/GYN	Mpls. MN.	7/75 — 9/1991
Private Practice Meadowbrook Womens Clinic	Mpls. MN	7/1975 → Present
Hennepin Faculty Associates, Henn. Co Med Center Univ of MN. Dept OB/GYN	Mpls. MN. ASSISTANT Professor OB/GY Mpls. MN.	9/1991 → 12/2004
Jo Lynn Hayden Ass., PA. (OB/GYN)	Private GYN Practice Mpls, MN.	1/2005 — Present

Applicant Name MELVIN J. FRISCH 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 <u>do not</u> report <u>pending</u> malpractice suits or <u>settlements paid not related to a civil action</u>.**	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: ***<u>In the event the response to any of the questions numbered 10 through 26 is "YES"</u>*****, 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 Melvin J Frisch, 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 Melvin J. Falsch, M.D. (4)

The applicant Melvin Julius Frisch, 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 Melvin J. Frisch M.D. **M.D.** **Date** 11/10/08

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 _____

Application Approved 12/19 20 08 by Suzann Drake

License Issued 12/31/08 JY License Number 41367

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

RECEIVED NOV 13 2008

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: Melvin J. Frisch, MD Class of 1966, M.D.

Melvin J Frisch MD 11/09/08.
Signature Date (Month/Day/Year)

(DO NOT DETACH)

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

This certifies that Melvin J. Frisch
(Name of applicant)

was enrolled in Univ. of MN Medical School Mpls., MN
(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 09/62 to 06/66
(month/year) (month/year)

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

_____ The applicant withdrew from

the above named Medical School on 06/11/1966.
(month /day /year)

Advanced credits – Credits granted upon admission

(name of medical school)	(total credits)	(dates attended)
	not on file	

(SEAL OF COLLEGE)

(If no seal, please indicate)

Signed: MD

Name Typed or Printed: KATHLEEN V. WATSON, M.D.

Title: ASSOC. DEAN OF STUDENTS AND STUDENT LEARNING Date 11/13/2008

Address: 420 DELAWARE ST. S.E., MAS., MN 55455

Telephone number: 612 624 8101 Fax number: 612 626-4200

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: Melvin J. Frisch (Rotating internship 6/1966 – 6/1967), M.D.

Melvin J. Frisch MD 11/09/08
Signature Date (Month/Day/Year)

(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: _____ **DEPARTMENT/SPECIALTY:** Rotating Internship
X **Internship**
_____ **Residency** **From:** 6 / 24 / 66 **To:** 6 / 30 / 67
_____ **Fellowship**
_____ **Research** **Successfully completed?** ✓ **Yes** _____ **No** _____ **In Progress**

PG/Year: _____ **DEPARTMENT/SPECIALTY:** _____
_____ **Internship**
_____ **Residency** **From:** ___/___/___ **To:** ___/___/___
_____ **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.

Signed: Sally R. Oliver
Name Typed or Printed: Sally R. Oliver, MPA
Title: Administrative Director, GME
Date _____

(SEAL OF TRAINING PROGRAM)
(If no seal, please indicate)

Full name of Hospital or Program: Harbor-UCLA Medical Center
Address: 1000 W. Carson St. Torrance, CA 90509
Telephone number: 310/222-2911 Fax number: 310/782-8599

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: Melvin J. Frisch, M.D.

Melvin J. Frisch MD 11/04/08
Signature Date (Month/Day/Year)

(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: 2-4 **DEPARTMENT/SPECIALTY:** Obstetrics & Gynecology
____ **Internship**
_X_ **Residency** **From:** 07 / 01 / 1972 **To:** 06 / 30 / 1975
____ **Fellowship**
____ **Research** **Successfully completed?** ____ **Yes** ____ **No** ____ **In Progress**

PG/Year: ____ **DEPARTMENT/SPECIALTY:** ____
____ **Internship**
____ **Residency** **From:** ____ / ____ / ____ **To:** ____ / ____ / ____
____ **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.

Signed: _____ (SEAL OF TRAINING PROGRAM)

Name Typed or Printed: Linda F. Carson, MD (If no seal, please indicate)

Title: Professor, Department Chair, Program Director Date 11/25/08

Full name of Hospital or Program University of Minnesota Medical School, OB/GYN & Women's Health

Address: MMC 395, 420 Delaware Street SE, Minneapolis, MN 55455

Telephone number: 612-626-3111 Fax number: 612-626-0665

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

November 13, 2008

NOV 18 2008

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

This is to certify that a standard search of the available records of the Minnesota Board of Medical Practice indicates the following:

Physician:	Melvin Julius Frisch
Date of birth:	[redacted]
Was issued license number:	17719
On:	July 3, 1967
Expiration date is:	September 30, 2009
Status:	Active
Issued on the basis of:	STATE - State Exam
Exam(s):	Exam 1: N/A, Score 1: 92.1
Corrective action:	None
Disciplinary action:	None

The above format is the standard format prepared for all physicians regulated by this board.

Please be advised that the Board does not release information as to whether there has been a complaint filed or an investigation conducted on individual verifications. All physicians are considered in good standing unless noted otherwise.

If other information is needed, please contact the Minnesota Board of Medical Practice.

Sincerely,

Pat Hayes

Pat Hayes
Licensure Specialist , Licensure Unit
Pat.Hayes@state.mn.us

VERIFIED
Licensing

EN-PY

Minnesota State Board of Medical Examiners

230 LOWRY MEDICAL ARTS BLDG., ST. PAUL 2, MINNESOTA

STATE BOARD EXAMINATION

Name MELVIN JULIUS FRISCH
Preliminary Education Virginia Jr.Coll.
Medical Education U. of Minnesota
School of Graduation " " "
Diploma Bachelor of Medicine
Diploma Doctor of Medicine June 11,1966
Internship

Application No. 75
Date June 14,15,16, 1966
License Number 17,719-f
Issued July 3,1967
Fee Paid $50.00 May 24,1966
Receipt No. 4021

THIS SIDE OF THIS SHEET IS FOR OFFICE RECORD. PLEASE DO NOT WRITE ON IT.

MINNESOTA STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES

MELVIN JULIUS FRISCH — EXAMINATION REPORT

Date of Examination June 2,3,1964 Apr.7,8,1964 — Certificate No. 16,902 — Dated June 3,1964

Anatomy	98	Hygiene	78
Bacteriology	87	Pathology	80
Chemistry	88	Physiology	90

Memo.

MINNESOTA STATE BOARD OF MEDICAL EXAMINERS

EXAMINATION REPORT

Physical Diagnosis	90	Materia Medica & Therapeutics	91
Medicine	100	Pediatrics	88
Surgery	86	Eye, Ear, Nose & Throat	94
Obstetrics & Gynecology	96	General Average	92.1

PERSONNEL OF BOARD

Howard L. Horns, M.D. Pres.
Austin M.McCarthy, M.D. Vice-Pres.
J. P. Hedeiman, M.D. Sec'y.
James C. Cain, M.D.
Dale Dodson D.O.
F. H. Magney, M.D.
Bror F. Pearson, M.D.
Russell O. Sather, M.D.

Location

Cert. copy / Memorandum

1. Minnesota Basic Science Certificate 16,902 issued MELVIN JULIUS FRISCH, June 3,1964 by examination.
2. University of Minnesota diploma conferring DOCTOR OF MEDICINE upon MELVIN JULIUS FRISCH June 11,1966(above recorded & returned June 13,1966)

Received Melvin J Frisch

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

CC

December 19, 2008

Melvin Julius Frisch, M.D.
[redacted]

Dear Dr. Frisch,

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 $187.50.** 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: MELVIN J. FRISCH, M.D.
Current Office Address: 825 So 8th ST. #1018 Minneapolis MN. 55403
Current Home Address: [redacted]
Current Mailing Address: [redacted]
Current Office Telephone 612-374-7708 Current Home Telephone [redacted]
~~Current Office E-Mail~~ _____ Current Home E-Mail [redacted]
Area of Interest: MENOPAUSE MANAGEMENT; FAMILY PLANNING Practicing: ☒ Yes ☐ No
in Mpls part time
looking for portun in Tucson

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

#41367
12/31/08

DEC 30

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

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

RECEIVED
MAR 18 2013
AZ MEDICAL BOARD

PHYSICIAN NAME: Melvin Julius Frisch

LICENSE #: 41367 SPECIALTY: Obstetrics & 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:**

Street Address 2255 N.Wyatt Drive				City/State/Zip Code Tucson, AZ 85712			
Phone Number 602-263-4210				Fax Number 602-604-0159		E Mail [redacted]	
Schedule II Drugs		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:**

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: Melvin J Frisch MD Date: 2/18/13

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

FRISCH, MELVIN J MD
5651 N. 7TH STREET
PHOENIX, AZ 85014-0000-000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	09-30-2015	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	12-06-2012

FRISCH, MELVIN J MD
2255 N. WYATT DR.
TUCSON, AZ 85712-0000

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]	09-30-2015	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	12-06-2012

FRISCH, MELVIN J MD
2255 N. WYATT DR.
TUCSON, AZ 85712-0000

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)

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	09-30-2015	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	12-06-2012

FRISCH, MELVIN J MD
2255 N. WYATT DR.
TUCSON, AZ 85712-0000

CONTROLLED SUBSTANCE/REGULATED CHEMICAL
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.

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:

Arizona Medical Board: License Renewal Questions

Melvin Frisch 2013 License # 41367 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]	
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

Melvin	Frisch	2013	License # 41367	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: License Renewal Questions

Melvin Frisch 2011 License # 41367 Professional Conduct

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	**No**	
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	**No**	
3. Since your last renewal have you voluntarily surrendered any healthcare license?	**No**	
4. Since your last renewal have you had any healthcare license revoked?	**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?	**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?	**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.	**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?	**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.	**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?	**No**	
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	**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?	**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?	**No**	

Arizona Medical Board: License Renewal Questions

Melvin	Frisch	2011	License # 41367	Mental Health

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 or 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? See below for definition of ability to practice medicine.

[redacted]

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 41367

Renewal Fee: ~~$500~~ **$850** (if postmarked 30 days after due date)

Name: Melvin J. Frisch, MD

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

825 S. 8th St.
#1018
Minneapolis MN. 55403

RECEIVED
SEP 08 2009
AZ MEDICAL BOARD

Phone #: 612-376-7708 **Fax #:**

E-Mail: [redacted]

MAILING ADDRESS [redacted] } until 11/1/09 then use [redacted] address below

HOME ADDRESS

Mpls. — [redacted] } May → Now

[redacted] } Now → May

Phone #: [redacted]

Mobile #: [redacted] phone #

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)
GYN	Yes	No	Lifetime.

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.)

Melvin J. Frisch — 9/4/09

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: Melvin J. Frisch, MD License Number: #41367

Signature: Melvin J. Frisch MD

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?**	[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.

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: Melvin J. Frisch, MD License Number: # 41367

Signature: Melvin J. Frisch MD