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

November 8, 2011

RE: Complaint information for Dr. Paul Isaacson

To Whom It May Concern:

The information you requested cannot be provided for the following indicated reason(s):

____ (A.) Name(s) do not match any licensed physician or physician assistant in our records.

____ (B.) The file you have requested has been destroyed in accordance with the agency's record retention schedule.

____ (C.) Transcripts are available through Griffin & Associates Court Reporters at (602) 264-2230.

____ (D.) This agency does not release physician/physician assistant's dates of birth or Social Security Numbers.

__X__ (E.) You have requested documents that are part of the Board's investigative file and are confidential pursuant to A.R.S. § 32-1451.01(C) and (E), and are exempt from disclosure to the public and not obtainable by subpoena. *Lipschultz v. Superior Court*, 128 Ariz. 16, 623 P.2d 805 (1985); *Arizona Board of Medical Examiners v. Superior Court*, 186 Ariz. 360, 911 P.2d 924 (App. 1996).

____ (F.) In addition to the reasons stated in (E), as the licensee you may have been entitled to receive this information while the investigation was pending. However, you would have been prohibited from using the material in any forum other than before the Board. Because the investigation is concluded, you are not entitled to this information. A.R.S. § 32-3206(B).

____ (G.) Other: The Arizona Medical Board does not have jurisdiction over the professions about which you requested information.

Comments:
Please contact the Clerk of Courts for malpractice information: 602-506-3360

Thank you,

Amanda Schwabe

Amanda Schwabe
Board Coordinator
Ph: (480) 551-2712
Fx: (480) 551-2705

MD PROFILE PAGE

Arizona Medical Board

azmd.gov
Printed on 11/09/11 @ 08:28

General Information

Paul A. Isaacson MD
1331 N 7th St Ste 225
Phoenix AZ 85006-2768
Phone: (602) 553-0440

License Number: 23227
License Status: Active
Licensed Date: 06/16/1995
License Renewed: 03/31/2011
Due to Renew By: 04/16/2013
If not Renewed, License Expires: 08/16/2013

Education and Training

Information up to the date of initial licensure is verified by the Board. Information provided by the physician after this date is not verified by the Board.

Medical School:	TUFTS UNIV SCH OF MED Boston, Massachusetts
Graduation Date:	05/12/1991
Residency:	07/01/1991 - 06/30/1995 (Obstetrics & Gynecology) BRIGHAM & WOMEN'S HOSPITAL-HARVARD MEDICAL SCHOOL BOSTON, MA
Area of Interest	Obstetrics & Gynecology (ABMS Board Certified)

The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

Board Actions

None

A person may obtain additional public records related to any licensee, including dismissed complaints and non-disciplinary actions and orders, by making a written request to the Board. The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

Please note that some Board Actions may not appear until a few weeks after they are taken, due to appeals, effective dates and other administrative processes.

Board actions taken against physicians in the past 24 months are also available in a chronological list.

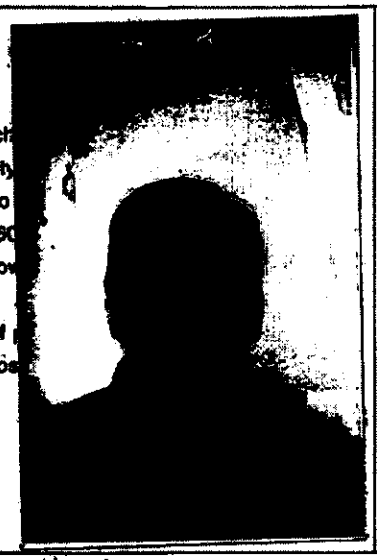
Credentials Verification professionals, please click here for information on use of this website.

ARIZONA BOARD OF MEDICAL EXAMINERS

FEB 2 1 1995

1651 E. Morten Avenue, Suite 210
Phoenix, Arizona 85020
A.C. (602) 255-3751

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE THROUGH ENDORSEMENT



Attach
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Proof
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FOR BOARD USE
DO NOT USE THIS SPACE

BOMEX

MAR 1 0 1995

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

INFORMATION

All candidates shall provide satisfactory evidence that:

1. He possesses a good moral and professional reputation.
2. He is physically and mentally able to engage safely in the practice of medicine.
3. He has not been found guilty of any act of unprofessional conduct; medical incompetency; or mentally or physically unable to engage safely in the practice of medicine.
4. He has not had disciplinary action taken against him by any other state, territory, district or country for reasons relating to his ability to engage safely and skillfully in the practice of medicine.

NOTE: Applications are processed on a first-come first-served basis; the processing of a routine application can take 10 to 12 weeks. Applications not fully complete within one year from date of receipt are considered withdrawn.

APPLICATION INSTRUCTIONS
(Read Carefully)

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

1. Evidence of name and date of birth: (a) a photocopy of birth certificate; or (b) an original Certificate of Naturalization; or (c) other documentary evidence for consideration. (Visa, green card, Passport, etc.)
2. Certified evidence of any legal name changes other than that shown on certificates filed in accordance with paragraph 1 above, (e.g., marriage certificate). Proof of foreign birth of American parents.
3. Photocopy of M.D. Degree Diploma; OR M.B., B.S. Degree Diploma for foreign graduates.
4. Photocopy of the DD 214 Form of release from the U.S. military or public health service. OR, if currently serving, have attached herewith a letter from any Commanding Officer setting forth the dates of active duty, assignments, and anticipated date of release from active duty.
5. Photocopies of any certificates awarded by any of the American medical specialty boards.
6. Photocopies of all certificates awarded upon completion of any internship, residency, fellowship or other post-graduate medical education undertaken in United States or Canadian hospitals; OR letters of certification of partial; past; or current training.
7. The names and addresses of all your hospital affiliations for the five years prior to filing this application and the Chief of Staff or Chief of Service for each.
8. A statement of your exact whereabouts and nature of practice or other activities from the date of graduation from medical school to the present, with specific MONTH AND YEAR listed for each. NO PERIOD UNACCOUNTED FOR IS ALLOWED.

9. Cashier's Check or Money Order in U.S. Funds (personal checks not accepted), covering the statutory fee of $450.00. There are no refunds.
10. Applicants, whose written examination; FLEX examination; National Board of Medical Examiners (NBME) or Licensing Medical Council of Canada (LMCC) certificates, upon which endorsement is sought was received more than ten years preceding the filing of this application, are required to submit to the Special Purpose Examination (SPEX).
11. Credentials submitted in foreign languages shall have affixed thereto a certified translation into English.
12. Separated or Mutilated Applications are not acceptable and will require refiling.
13. Requests for exemptions or waivers of any portion of this application will be denied and will delay your consideration for licensure.
14. **NOTE:** All credentials submitted must remain the property of the Arizona Board of Medical Examiners and NONE will be returned except original Certificates of Naturalization or the applicant's triplicate copy of Declaration of Intention.
15. Photocopies shall not exceed 8½ inches by 11 inches in size.

UNITED STATES OR CANADIAN MEDICAL SCHOOL GRADUATES

Graduates of medical schools located in the United States or Canada which were approved by the Council on Medical Education of the American Medical Association, the Canadian Medical Council, or the Association of American Medical Colleges, will forward forms numbered I, II, and III to the appropriate agency with the request that they be completed and returned directly to the Arizona Board of Medical Examiners.

ALL OTHER MEDICAL SCHOOL GRADUATES

Graduates of medical schools located outside the United States or Canada will forward Forms numbered I, II, III, III-A, and IV as may be applicable, to the appropriate agency with the request that they be completed and returned to the Arizona Board of Medical Examiners.

Note: Applications will not be processed nor considered until ALL required forms are completed and returned directly to the Arizona address provided.

APPLICATION

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

1. Present Legal Name: PRINT OR TYPE ISAACSON (Last), PAUL (First) ALLEN (Middle) (Maiden)
   (a) Other names used: _____ Social Security No. [redacted]
2. Address: Residence: [redacted]
   Office _____ (No.) (Street) (City) (State) (Zip Code) (Phone)
3. City and State of Birth [redacted] Month, Day and Year of Birth [redacted]
4. In what states or provinces have you applied for or been granted license or registration? If more than two, attach separate listing. If license not issued, so state.
   (a) MASSACHUSETTS (Specify State Board) 3/28/93 (Date of Application) License granted (Result) 77622 (Certificate No.)
   5/12/93 (Date Issued) credentials (Specify if by Written Examination or on Credentials)
   (b) _____ (Specify State Board) _____ (Date of Application) _____ (Result) _____ (Certificate No.)
   _____ (Date Issued) _____ (Specify if by Written Examination or on Credentials)
5. Have you ever had an application for a license to practice medicine denied or rejected by another state/province licensing Board? NO (Answer)
6. Have any actions, restrictions, limitations, or probations ever been imposed on you while participating in any type of training program? NO (Answer)
7. Have you ever been charged with a violation of any statute, rule or regulation of any domestic or foreign governmental agency? NO (Answer)
8. Has there been any action initiated against you by or through any medical board or association? NO (Answer)
9. Have you ever had a medical license revoked; suspended; limited; restricted; placed on probation; voluntarily surrendered or cancelled during an investigation or in lieu of disciplinary action; or entered into a consent agreement or stipulation? NO (Answer)

10. Have you ever had hospital privileges revoked; denied; suspended or restricted in any way? NO (Answer)

11. Have you ever been involved in any malpractice matter which resulted in a settlement or judgement against you in excess of $20,000? NO (Answer)

12. Have you ever been convicted of Medicare or Medicaid fraud; received sanctions, including restriction, suspension or removal from practice imposed by an agency of the federal government? NO (Answer)

13. Have you ever had your ability to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered or revoked by a federal or state agency? NO (Answer)

Note: In the event the response to any of the questions numbered 5 through 13 is YES, the applicant will file with the application a detailed report concerning the above matters; including, any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the results of any hearings, and the disposition of such charge(s). Provide the name and address of applicant's insurance carrier and the name and address of patient's attorney. IN ADDITION, the applicant must provide that certified photocopy(ies) of any hearings, settlements or judgements, together with copies of patient's hospital and/or office records, be submitted to this Board.

14. Have you ever been treated for the use of or misuse of any chemical substance or substances? [redacted] (Answer)

15. Have you ever been hospitalized or a patient in a mental or other institution of confinement, or have you ever been treated or received medication for a mental or behavioral condition? [redacted] (Answer)

16. Are you suffering from any ailment communicable to others? [redacted] (Answer)

Note: In the event the response to the questions 14 through 16 is YES, the applicant will file with the application a separate detailed statement concerning the above matter(s); including the name and address of the hospital/rehabilitation center where treatment was obtained. The applicant shall also obtain and furnish a certified copy of his/her History and Physical Examination, Consultation Report(s), and Discharge Summary from the hospital/rehabilitation center. The applicant shall also have submitted a statement from his/her attending physician or treating therapist setting forth the applicant's diagnosis, prognosis and recommendations for continuing care, treatment and supervision.

17. Are you presently in good physical and mental health? [redacted] (Answer)

(If NO, applicant shall file with this application, a detailed statement of his health, diagnosis and prognosis, supported by report of his attending physician.)

18. Enter your height here 5'6" weight 172 color of eyes Blue color of hair Brown

19. List Internships, Residency and Fellowship training; OR, Assistant Professorship (or higher) at approved school of medicine — chronologically showing institution, address, type of program and dates. Attach separate listing if needed.

INTERNSHIP 6/91 TO 6/92 Brigham and Women's Hospital 75 Francis St. Boston, MA 02115 OB/GYN

Residency 6/92 TO 6/95 Brigham and Women's Hospital 75 Francis St. Boston, MA 02115 OB/GYN

20. Are you certified by an American Board of medical specialties? NO Specialty: _____

21. Have you completed the educational requirements for any of the American Board of medical specialties? NO If so, which? _____

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

At Boston, MA - Internship and Residency (City / State) from 6/91 to present.

At _____ (City / State) from _____ to _____

At _____ (City / State) from _____ to _____

At _____ (City / State) from _____ to _____

At _____ (City / State) from _____ to _____

At _____ (City / State) from _____ to _____

23. In the event you are successful in obtaining a license to practice medicine by this application, have you selected a location?
yes Where? Chandler, AZ
Solo or in Association with? Women's Health Care Associates
24. What is your intended specialty practice? Obstetrics and Gynecology
25. What branch of the United States Armed Forces have you served with, if any, including USPHS? None
Active duty? From _____ to _____
Month and Year Month and Year

The applicant PAUL ALLEN ISAACSON, MD
(PRINT OR TYPE) (Name in Full)

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

Signature of Applicant Paul Isaacson, M.D.

STATE OF MA
County of Suffolk } ss

(NOTARIAL SEAL)

Subscribed and sworn to before me this 6 day of March 1995

Notary Signature Marta Wellman My Commission expires June 9, 2000
(Notary Public)

FOR OFFICE USE ONLY

Application Rec'd	3-10- 19 95	Application Processed by	JA
Application Completed	19	Application Checked by	MS
Form No. I Rec'd	3-17- 19 95	Application Approved	June 5, 19 95
Form No. II Rec'd	3-20- 19 95	By	Marie Naughton
Form No. III Rec'd	3-13- 19 95	License Issued	June 16, 19 95
Form No. III Rec'd	19	License No.	23227
Form No. III-A Rec'd	19		
Form No. IV Rec'd	19		
Investigation Completed	19		
Application withdrawn	(Date)		

PLEASE RETURN THIS FORM WITH YOUR APPLICATION
MAY BE XEROXED IF ADDITIONAL COPIES ARE NEEDED

ARIZONA BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

APPLICANTS: List all hospital affiliations for the past five (5) years, including moonlighting and courtesy staff affiliations.

List all employment with medical agencies of employment, e.g., physician placement group; emergency medical group radiology group; etc.

1) HOSPITAL: Brigham and Women's Hospital - Robert Carabieri, MD chief of staff

ADDRESS: 75 Francis St. Boston, MA 02115
City State Zip Code

DATE OF STAFF MEMBERSHIP: 6/91 - present

TYPE OF STAFF MEMBERSHIP: House staff

2) HOSPITAL: Massachusetts General Hospital - Isaac Schiff MD chief of staff

ADDRESS: 32 Fruit St. Boston, MA 02111
City State Zip Code

DATE OF STAFF MEMBERSHIP: 6/61 - Present

TYPE OF STAFF MEMBERSHIP: HouseStaff.

3) HOSPITAL: _____

ADDRESS: _____
City State Zip Code

DATE OF STAFF MEMBERSHIP: _____

TYPE OF STAFF MEMBERSHIP: _____

4) HOSPITAL: _____

ADDRESS: _____
City State Zip Code

DATE OF STAFF MEMBERSHIP: _____

TYPE OF STAFF MEMBERSHIP: _____

5) MEDICAL AGENCY OF EMPLOYMENT: _____

ADDRESS: _____
City State Zip Code

DATE OF EMPLOYMENT: _____

BOMEX

MAR 1 0 1995

6) MEDICAL AGENCY OF EMPLOYMENT: _____

ADDRESS: _____
City State Zip Code

DATE OF EMPLOYMENT: _____

Photo on Back

FORM I

MEDICAL COLLEGE CERTIFICATION

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the medical school granting the medical degree. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 1651 EAST MORTEN AVENUE, SUITE 210, PHOENIX, ARIZONA 85020. Your early response will be appreciated.

Name: PAUL A. ISAACSON (Please Print or Type), M.D. [signature] (Signature), M.D.

Address: [redacted] (Street) [redacted] (City and State)

Date: 3/5/95

(DO NOT DETACH)

(This section with a current photograph of the applicant shall be forwarded to and completed by an officer of the medical school granting the medical degree. Please indicate to your medical school that this completed form must be returned to the Arizona Board of Medical Examiners.

This is to certify that Paul Allen Isaacson (Full Name of Student)

whose photograph is attached hereto, was granted the degree of Doctor of Medicine by

Tufts University School of Medicine on May 12 19 91,
(Full Name of School or College of Medicine as it appears on the Applicant's Medical degree diploma)

that the date of his/her matriculation in medical school was August 31, 1987; and that he/she attended 40 (Number) full courses of medical lectures comprising 1-1.5 (Number) months each as verified by the attached certified copy of his/her transcripts.

1. Was applicant ever required to repeat any segment of training? NO If YES, which part(s)?

2. Was applicant ever placed on probation, restricted or limited? NO If YES, please attach written explanation.

3. Was there any reason not to continue applicant in the training program? NO If YES, please attach written explanation.

4. Was applicant ever known to use or misuse any chemical substance or substances which required treatment or counseling? [redacted] If YES, please attach written explanation.

5. Was applicant ever known to suffer from any mental health disorders which required treatment, counseling or medications? [redacted] If YES, please attach written explanation.

6. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed Barbara A. Chernow, M.D.

Dean / President / Secretary / Registrar of Dean for Students

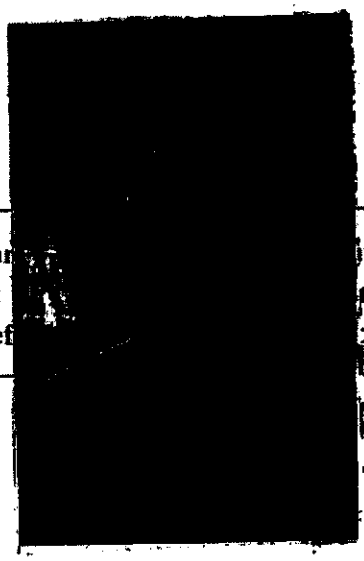
(SEAL OF COLLEGE) Date MAR 13 1995, 19

Address: 136 Harrison Ave Boston MA 02111

Please return completed form DIRECT to:
Arizona Board of Medical Examiners, 1651 E. Morten Avenue, Suite #210, Phoenix, Arizona 85020

Revised 4/91

RECEIVED B.O.M.E.X.
MAR 17 95



The applicant must assu[redacted]pletion of this form and is forewarned that it must [redacted]arded to the Arizona Board of Medical Examiners bef[redacted]onsidered.

Universitas Tuftensis

in Republica Massachusettensi

Omnibus ad quos hae litterae pervenerint salutem plurimam dicit

Praeses Universitatis Tuftensis

honorandis ac reverendis Curatoribus iubentibus
doctis ac eruditis Professoribus probantibus
Scholae eius quae scientiam medicinae colit,

Paul A. Isaacson

ad gradum **Medicinae Doctoris** *admisit eique fruenda dedit et concessit omnia iura, honores, insignia, privilegia ad hunc gradum pertinentia. In cuius rei testimonium, litteris hisce Sigillo Academico munitis ante diem* IV *Id. Mai* MCMXCI
nos Praeses Universitatis et Decanus Scholae auctoritate nobis commissa nomina subscripsimus.

Richard M. Doyle Jr.
Decanus

SIGILLUM UNIVERSITATIS TUFTENSIS

Praeses

FORM III

POSTGRADUATE TRAINING CERTIFICATION

TO WHOM IT MAY CONCERN:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved post-graduate training program in the United States or Canada. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 1651 EAST MORTEN AVENUE, SUITE 210, PHOENIX, ARIZONA 85020. Your early response will be appreciated.

Name: PAUL A. ISAACSON, M.D. (Please Print or Type) Paul Isaacson, M.D. (Signature)

Address: [redacted] (Street) [redacted] (City and State)

Date: 3/5/95

(DO NOT DETACH)

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

This is to certify that Paul Isaacson (Name of Applicant in Full), M.D. undertook and satisfactorily completed a full term approved program of 48 (Number) months in the: Brigham & Women's Hospital (Full Name and Complete Address of Hospital)

75 Francis Street, Boston, MA 02115

in the field of Obstetrics ans Gynecology from 7/1/91 (Date) to 6/30/95 (Date/Anticipated Date)

and that the said program was approved for post-graduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. YES X NO ____

1. Was applicant ever required to repeat any segment of training? NO If YES, which part(s)? ____
2. Was applicant ever placed on probation, restricted or limited? NO If YES, please attach written explanation.
3. Was there any reason not to continue applicant in the training program? NO If YES, please attach written explanation.
4. Was applicant ever known to use or misuse any chemical substance or substances which required treatment or counseling? [redacted] If YES, please attach written explanation.
5. Was applicant ever known to suffer from any mental health disorders which required treatment or counseling? [redacted] If YES, please attach written explanation.
6. Were applicant's final evaluations in every category rated satisfactory and/or above? YES If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed Robert J. [illegible]

(SEAL OF HOSPITAL) (So indicate, if copy)

Title Chairman, Department of Obstetrics & Gynecology

Address 75 Francis Street Boston, MA 02115 Date 3 6, 1995

RECEIVED B.U.M.E.X.

MAR 13 95

Revised 5/89

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

Diplomate Name: Paul A. Isaacson, MD

Date of Birth: [redacted]

Certification Date: 07/01/1992 **Certificate #:** 396199

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME PART I	Jun 1989	625 89	380 75	PASS	595 88	595 88	620 89	595 88	580 87	590 87	655 91
					Med	**Surg**	**Ob/Gyn**	**PM/PH**	**Ped**	**Psych**	
NBME PART II	Sep 1990	570 84	290 75	PASS	560 84	560 84	610 86	540 83	540 83	540 83	
NBME PART III	Mar 1992	625 86	315 75	PASS							

DATE: 03/13/1995

SEE OTHER SIDE FOR SCORE INFORMATION

RECEIVED B.O.M.E.X. AZ1060

MAR 20 95

This NBME *Endorsement of Certification* may include scores for Step 1 and Step 2 of the United States Medical Licensing Examination™ (USMLE™). The USMLE, established by the Federation of State Medical Boards and the NBME, is a single, uniform medical licensure examination system comprised of three Step examinations. USMLE replaces both the Federation Licensing Examination (FLEX) and the NBME Parts I, II and III. Implementation of USMLE began with the administration of Step 1 in June 1992. The first administration of Step 3 will occur in June 1994. The NBME accepts passing scores on Part I or Step 1, plus Part II or Step 2, plus Part III or Step 3 as meeting the examination requirements for its certification program.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

NBME Part I and Part II Examinations June 1991 and Thereafter

The most recent total test score is reported. This score is on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

Step 1 and Step 2 of the United States Medical Licensing Examination (USMLE)

The complete USMLE examination history is given. A total test score is reported on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

All NBME Part III Examinations

The most recent total test score is reported. This score is on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Two-Digit Scores

For all examinations, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

EXPLANATION OF COMMENTS

For USMLE Step 1 and Step 2, this document is annotated to reflect special circumstances regarding the score report.

If you wish to obtain further information about individual examinees who have notations under "Comments," please write the NBME Supervisor of Examinee Records.

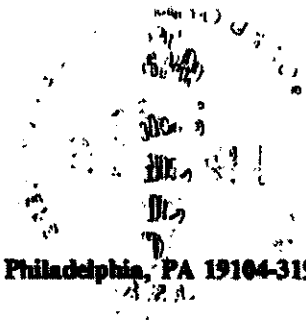
Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. No score is reported.

Incomplete - The examinee sat for some but not all of the scheduled test books. No score is reported.

Irregular Behavior - The USMLE Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. To determine the exact nature of the irregular behavior, the examinee's full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat at (215)590-9600.

Score Not Available - Score not available pending further review and/or analysis.

Special Testing Accommodations - Following review and approval of a request from the examinee, special testing accommodations were provided in the administration of the examination.



BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

SATISFACTION OF REQUIREMENTS SUMMARY

ENDORSEMENT

APPLICATION Received March 10, 1995

NAME IN FULL ISAACSON (Last) PAUL (First) ALLEN (Middle)

Current Address [redacted]

Telephone [redacted] (Residence) (617) 732-6987 (Office)

BIRTHPLACE [redacted] (City) (State) (Country) Date [redacted]

CITIZENSHIP Check One: ☒ Native ☐ Naturalized Declared Intention On

MEDICAL EDUCATION Tufts University School of Medicine, Boston, MA 024-07
(Full Name and Location of Medical School)
M.D. Awarded: May 12, 1991 Proof Received: March 17, 1995 ☒ Approved
ECFMG Certificate No. Dated: Proof Received:

FORM III In OBG (Field of Training) for 48) months at Brigham & Women's Hospital, Boston, MA (Name of Institution)
From July 1, 1991 to June 30, 1995

POSTGRADUATE TRAINING
In (Field of Training) for months at (Name of Institution)
From to

In (Field of Training) for months at (Name of Institution)
From to

In (Field of Training) for months at (Name of Institution)
From to

In (Field of Training) for months at (Name of Institution)
From to

In (Field of Training) for months at (Name of Institution)
From to

AMERICAN BOARD Of None (Specialty) Certificate No. Issued
Of – (Specialty) Certificate No. Issued

PRACTICE Field of OBG (Current)

FORM II

SPEX EXAM:	DATE:	SCORE:	PROOF REC'D
Endorsement through National Board	; No. 396199 (Certificate)	; Issued 7/1/92 (Date)	W/E

LICENSES

Massachusetts; #77622, 5/12/93	; [ ] W/E	[ ] FLEX	☒ Recip. With	National Board
In	; [ ] W/E	[ ] FLEX	[ ] Recip. With	
In	; [ ] W/E	[ ] FLEX	[ ] Recip. With	
In	; [ ] W/E	[ ] FLEX	[ ] Recip. With	
In	; [ ] W/E	[ ] FLEX	[ ] Recip. With	
In	; [ ] W/E	[ ] FLEX	[ ] Recip. With	
In	; [ ] W/E	[ ] FLEX	[ ] Recip. With	
In	; [ ] W/E	[ ] FLEX	[ ] Recip. With	
In	; [ ] W/E	[ ] FLEX	[ ] Recip. With	

(TUMBLE)

ISAACSON, PAUL A.: CONTINUED:

U.S. MILITARY OR PUBLIC HEALTH SERVICE	Served in None (Branch)	From	to
	Honorable Discharge Received	Discharge Rank	
PREVIOUS PRACTICE	In Boston (internship/residency) MA	From July 1, 19 91	to June 30, 19 95
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
FEES	Temporary $ Receipt #	Examination $	Receipt #
	Locum Tenens $ Receipt #	Endorsement $450.00	Receipt # A064 169
INVESTIGATION	AMA Approval 3/20/95, Record Clear, N/D		
	Massachuset Board Approval 3/20/95, cert.#77622, iss.5/12/93, End., Current, N/D		
	Fed. State Board Approval 3/16/95, Record Clear, N/D		
	Board Approval		
	Board Approval		
	Board Approval		
	Board Approval		
	Board Approval		
	Board Approval		
	Board Approval		
	Board Approval		
	Ass'n Approval		
	Ass'n Approval		
	Ass'n Approval		
INTENDED LOCATION	Chandler (assoc. w/Women's Health Care Associates)		

jd 5/19/95

ARIZONA BOARD OF MEDICAL EXAMINERS

June 16, 1995

Paul Allen Isaacson, M.D.
[redacted]

Dear Dr. Isaacson:

Congratulations! Your certificate to practice medicine in the State of Arizona, License No. 23227, issued on June 16, 1995, is enclosed with your wallet registration card for the current year.

Please be advised that annual re-registration is mandatory on a calendar-year basis. Arizona statutes provide that each licentiate renew registration on January 1st of every year. To maintain a current license, you are required to pay an annual renewal fee. Notification of renewal will be mailed to your address of record on or about November 1st of each year. Failure to re-register will result in statutory expiration of your license. It is your responsibility to keep the Board informed of address changes. Arizona Revised Statutes §32-1435 (B) provides that:

> "Each person holding a current license to practice medicine in this state shall promptly and in writing inform the Board of his current residence and office address and of each change in his residence and office address that may later occur."

Enclosed for your information is the section of the Arizona Medical Practice Act which pertains to Unprofessional Conduct. It is the responsibility of all licentiates in practice in Arizona to report directly to the Board of Medical Examiners any misconduct, unprofessional conduct or medical incompetence on the part of your colleagues which may come to your attention. According to A.R.S. § 32-1451 (A), failure to do so is actionable against your license to practice. You will receive a copy of the Arizona State Medical Directory published annually by the Board which contains the Arizona Medical Practice Act. It is suggested that you familiarize yourself with such prior to establishing your practice in Arizona.

In addition, included with this letter is information regarding Continuing Medical Education requirements and Prescription Form requirements.

Please contact Becky Drew, Licensing Manager, Extension 7101, should you have any questions.

Sincerely,

BOARD OF MEDICAL EXAMINERS STATE OF ARIZONA

Elaine Hugunin

Elaine Hugunin
Deputy Director

Enclosures

1651 East Morten, Suite 210 • Phoenix, Arizona 85020 • Telephone (602) 255-3751 • FAX (602) 255-1848

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020, (602) 255-3751

June 5, 1995

Paul Allen Isaacson, M.D.

[redacted]

Dear Dr. Isaacson:

RE: LICENSURE THROUGH ENDORSEMENT

The Board of Medical Examiners, State of Arizona, is pleased to inform you that your application and credentials for a license to practice medicine in the State of Arizona has been approved.

Arizona Revised Statutes provide for an initial registration of each licentiate and the certificate of license may not be issued until this is in hand. Please complete the enclosed card and return it to the Board of Medical Examiners, State of Arizona, 1651 E. Morten Avenue, Suite 210, Phoenix, AZ 85020. In order for your license to be issued, this card must be received by Thursday of each week. Your license may then be issued the following day, Friday. **YOU MUST NOT COMMENCE THE PRACTICE OF MEDICINE IN THE STATE OF ARIZONA UNTIL A LICENSE NUMBER HAS BEEN ISSUED TO YOU.**

The Board publishes an annual directory of all licentiates in this State, which is distributed around October of each year. Information for this publication is taken from the registration card which you complete. Home addresses and telephone numbers are **not** published, **unless this is the only address which you provide to the Board.** The deadline for receipt of address changes for inclusion in this directory is **July 31st** of each year. If you anticipate a move before that date, please indicate your new address(es) with the effective date as well as your current address(es).

ENCLOSED, PLEASE FIND OUR RECEIPT #A064169 FOR $450.00 FOR LICENSURE FEE.

Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Jackie Downing
Licensing Technician

[approval.ltr]

RAFIK ATTIA, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

An Agency within the Executive Office of Consumer Affairs and Business Regulation

March 16, 1995

To Whom It May Concern:

This is to certify that PAUL A ISAACSON

a graduate of TUFTS UNIVERSITY SCHOOL OF MEDICINE in the year 1991

has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 77622 was issued to Dr. PAUL A ISAACSON

on 05/12/93. THIS LICENSE IS CURRENT.

Expiration date: 04/16/96

Our files contain NO OPEN or CLOSED complaints, and NO formal disciplinary action regarding this physician.

Nishan J. Kechejian M.D.

Nishan J. Kechejian, M.D.,
Secretary

SEAL

Please be advised that the above information is based entirely on examination of our open and closed complaint file. It is not based on a review of the application for licensure, renewal of licensure or any reports that the Board is required to receive by statute (from Courts, Insurers, Hospitals, etc.).

BOMEX

MAR 9 6

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 E. Morten Avenue, Suite 210, Phoenix, AZ 85020

KINDLY COMPLETE AND SEND TO THE FEDERATION OF STATE MEDICAL BOARDS AT THE ADDRESS BELOW.

DATE: 3/5/95

Coordinator, Disciplinary Data Bank
Federation of State Medical Boards
6000 Western Place, Suite #707
Fort Worth, Texas 76107

RECEIVED
MAR 09 1995
By

The ARIZONA BOARD OF MEDICAL EXAMINERS requests a disciplinary search concerning the following individual:

ISAACSON, PAUL ALLEN
NAME: (LAST) (FIRST) (MIDDLE)

[redacted]
ADDRESS:

[redacted]
City, State and Zip

[redacted] ✓
Date of Birth

[redacted]
Social Security Number

TUFTS UNIVERSITY School of Medicine BOSTON, MA
Medical School of Graduation and Branch Location

5/91
Date of Graduation

WE HAVE NO DISCIPLINARY INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAR 14 1995

James R. Winn, M.D.
JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

Please mail the response to the following:

Arizona Board of Medical Examiners
1651 East Morten Avenue, Suite 210
Phoenix, Arizona 85020

Paul A. Isaacson M.D.
Signature

RECEIVED B.O.M.E.X.
MAR 16 95

DEC 15 1994

ISAACSON, Paul
(FOR OFFICE USE ONLY)

PREELIMINARY QUESTIONNAIRE

(ENDORSEMENT)

THIS IS NOT AN APPLICATION FOR LICENSE

To respond accurately to your recent inquiry, we will need the answers to *all* of the following questions to determine your eligibility for Arizona licensure. *Unless this Preliminary Form is completed in full and all questions answered, it cannot be evaluated, nor an application sent to you.* Return the completed form as soon as possible to: ARIZONA BOARD OF MEDICAL EXAMINERS, 1651 East Morten Avenue, Suite 210, Phoenix Arizona 85020. PLEASE *PRINT* ALL INFORMATION.

Full Legal Name: Paul (FIRST) Allen (MIDDLE) Isaacson (LAST)

Current Office Address: Brigham and Women's Hospital Dept. of OB/GYN. 75 Francis St

Area Code: 617

City: Boston State: MA Zip Code: 02115 Phone: 732-6987 Beeper 3203

Current Residence Address: [redacted]

Area Code: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted] Phone: [redacted]

MEDICAL SCHOOL: Name: Tufts University School of Medicine 024-07

City and State: Boston, MA Date of Degree: 6/91

If transferred from other medical school, please indicate name:

Name of any medical school attended but did not graduate or transfer from:

5TH PATHWAY PROGRAM: U.S. Medical School:

HOSPITAL: City: State:

Term: Started: (MONTH AND YEAR) Completed: (MONTH AND YEAR)

INTERNSHIP: (List U.S. & Canadian only) **HOSPITAL:** Brigham and Women's Hospital

75 Francis St. City: Boston State: MA

Term: Started: 6/91 (MONTH AND YEAR) Completed: 6/92 (MONTH AND YEAR)

RESIDENCY/FELLOWSHIP: (List U.S. & Canadian only) **HOSPITAL:** Brigham and Women's Hospital

75 Francis St. City: Boston State: MA

Term: Started: 6/92 (MONTH AND YEAR) Completed: 6/95 (MONTH AND YEAR)

Specialty Field: Obstetrics and Gynecology

RESIDENCY/FELLOWSHIP: (List U.S. & Canadian only) **HOSPITAL:**

City: State:

Term: Started: (MONTH AND YEAR) Completed: (MONTH AND YEAR)

Specialty Field:

FOR OFFICE USE ONLY

INFORMATION FORM FORWARDED 19

RECIPROCITY - EXAM APPLICATION FORWARDED 2-21- 1995

APPLICATION & FORMS I II III III-A IV

FEB - 1 1995

NB) 2 AMA) FS, HIC

CLINICAL INSTRUCTOR - ASSISTANT PROFESSOR OR HIGHER (List U.S. & Canadian only):

TEACHING HOSPITAL: _____

City: _____ State: _____

Medical School Affiliate: _____

Term: Started: _____ (MONTH AND YEAR) Completed: _____ (MONTH AND YEAR)

Specialty Field: _____

(NOTE: Attach separate list for additional Residency/ Fellowship/ Clinical Instructor)

FOREIGN MEDICAL SCHOOL GRADUATES: ECFMG Cert. No. _____ Date Issued: _____

CLINICAL WRITTEN EXAMINATION: Refer to last page for required FLEX/ SPEX scores.

Please indicate which examinations you have succesfully passed:

NATIONAL BOARD	USMLE	FLEX (taken after 1/1/85)
Part I 6/89 (date)	Step I _____ (date)	Comp. I _____ (date)
Part II 9/90 (date)	Step II _____ (date)	Comp. II _____ (date)
Part III 3/4/92 (date)	Step III _____ (date)	

FLEX examination taken prior to January 1, 1985 _____ (date)

Were grades achieved all in one sitting? _____ (yes) _____ (no)

State Board exam? ____ Name of State _____ License No. _____ Date iss. _____

LMCC (Canadian) _____ Cert. No. _____ Date iss._____

SPECIAL PURPOSE EXAMINATION:

(SPEX): _____ (STATE) Date SPEX examination taken: _____ (MONTH & YEAR)

Did you receive a minimum grade of seventy-five (75) ? _____

Are you a Diplomate of any of the *American* Medical Specialty Boards? Yes _____ No _____ .

If "Yes", which Board(s)? _____

Have you completed the educational requirements for any of the *American* Medical Specialty Boards?

Yes _____ No _____ . If "Yes", which Board(s)? _____

LICENSES: List *all* States or Provinces in which you **have ever** held licensure.

(1) Massachusetts (2)_____ (3)_____ (4)_____ (5)_____

(6) _____ (7)_____ (8)_____ (9)_____ (10) _____

LIST all hospital affiliations and locations for the past five (5) years (Other than Postgraduate Training Hospitals): Please list all hospital affiliations (including moonlighting) and medical agencies of employment, e.g., physician placement group; emergency medical group; radiology group, etc.: _____

None except postgraduate training

(NOTE: Attach separate list for additional hospital affiliations/medical agencies)

PRACTICE: City & State Where You Now Practice: IN Residency

Date Above Practice Was Established: _____

U.S. CITIZENSHIP:

(X) Birth
( ) Naturalization
( ) Declaration of Intention
( ) Hold Permanent Immigrant Status
( ) Awaiting Quota Assignment

BIRTHPLACE: [redacted] **DATE OF BIRTH:** [redacted]

MILITARY (United States Only):

( ) Army ( ) Air Force ( ) USPHS
( ) Navy ( ) Marine Corps ( ) Coast Guard

Dates of Active Duty: _____ Type of Discharge: _____

Has any formal disciplinary or rehabilitation action including reprimand, censure, probation, restriction, limitation, suspension or revocation been taken against your license in any State/ Province? Yes ____ No X

Have you ever entered into a written consent agreement or stipulation with a State/ Province licensing or disciplinary agency? Yes ____ No X

If "Yes", indicate State/ Province _____

Reason for action and action taken: _____

(NOTE: Attach separate sheet, if necessary)

Have you ever been convicted of Medicare/ Medicaid fraud? Yes ____ No X

If "Yes", when? _____

_____ Where? _____

Have your prescription/dispensing/or administration abilities ever been denied, restricted or modified by a Federal/ State/ Province government agency? Yes ____ No X

If "Yes", when? _____

Where? & By Which Agency? _____

Have you ever been involved in any malpractice matter which resulted in a settlement or judgement against you in excess of $20,000? Yes ____ No X

Have you ever had hospital privileges revoked; denied; suspended or restricted in any way? Yes ____ No X

If "Yes", name and address of hospital(s) _____

(NOTE: Attach separate sheet, if necessary)

I DECLARE UNDER PENALTY OF PERJURY that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this Preliminary Questionnaire, I hereby agree that such shall constitute cause for the denial of my eligibility to apply for licensure as an allopathic physician in the State of Arizona.

SIGNATURE: Paul Eisman, M.D. DATE: 2/6/95

1995

REQUIREMENTS FOR ARIZONA LICENSURE

FOR GRADUATES OF APPROVED MEDICAL SCHOOLS (United States or Canada)

A. Must have successfully completed 12 months hospital internship, residency or fellowship program which was approved by the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, the Royal College of Physicians and Surgeons of Canada or any similar body in the United States or Canada whose function is that of approving training programs.

B. Must have successfully passed a complete written examination conducted by any state, territory or district of the United States, or be certified by the National Board of Medical Examiners as having passed either, all three parts of the National Board examination or all three Steps of the United States Medical Licensing examination, or be certified by the Licensing Medical Council of Canada, or passed the Federation Licensing Examination.

Note: If applicant's written examination was the FLEX exam taken prior to January 1, 1985, must have been taken in one sitting and must have achieved a FLEX weighted average of at least 75.

If FLEX was taken after January 1, 1985, both Component I and Component II must have been passed within a 5 year period and must have received at least a 75 in each Component.

If applicant's written examination was the USMLE exam, all three Steps must have been taken within a 7 year period and must have received at least a 75 in each Step.

The following combinations of examinations (hybrids) are acceptable if taken from June 1, 1992 to July 31, 1995:

1.) Parts One and Two of the NBME *AND* either Step Three of the USMLE or Component II of FLEX.

2.) FLEX Component I *AND* Step Three of the USMLE.

3.) *EACH* of the following:

i.) NBME Part One or Step One of the USMLE

ii.) NBME Part Two or Step Two of the USMLE

iii.) NBME Part Three or Step Three of the USMLE or Component II of FLEX

C. An applicant seeking licensure by endorsement based on successful passage of a written examination which precedes by more than 10 years his application for licensure in this state, shall take and successfully complete a Special Purpose Examination (SPEX). An applicant who fails the SPEX exam 3 times, shall prove to the Board that he/she successfully completed an additional twelve months approved postgraduate training before retaking SPEX.

D. Must file an application for licensure by either Endorsement or Endorsement & SPEX.

E. Must pay all fees.

F. Must contact the Federation of State Medical Boards at 6000 Western Place, Suite 707, Fort Worth, Texas 76107, to request that all FLEX and USMLE scores be sent to this office. The Federation charges $40.00 for this service. (Scores must be received in this office before any application will be forwarded to the applicant.)

FOR GRADUATES OF UNAPPROVED ALLOPATHIC MEDICAL SCHOOLS

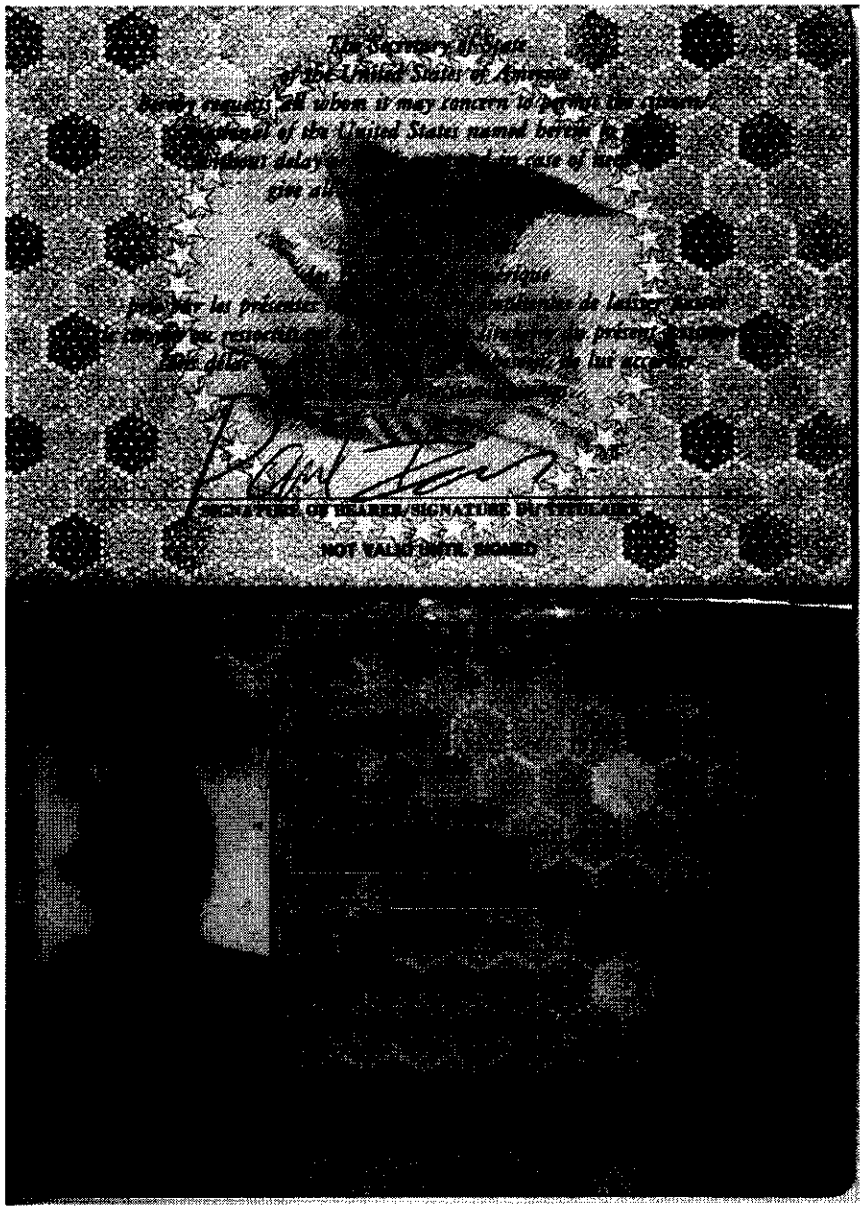
in addition to the above requirements, the following must be met:

1.) Hold a standard certificate issued by the Educational Council for Foreign Medical Graduates, complete a Fifth Pathway program, or complete thirty-six months as a full-time Assistant Professor or higher position in an approved school of medicine.

2.) Successfully complete an approved twenty-four month hospital internship, residency or clinical fellowship program in addition to A. above, for a total of thirty-six months, unless the applicant successfully completed a Fifth Pathway program, or has served as a full-time Assistant Professor or higher position at an approved school of medicine.

Note: The above examination requirements are statutorily set and cannot be waived by the Board.

Revised: 7/93



ARIZONA MEDICAL BOARD

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

RECEIVED JUL 7 2004 By

Pd CC

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: PAUL A. ISAACSON, MD

LICENSE #: 23227 SPECIALTY: GYNECOLOGY

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

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

PLEASE NOTE

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

PRIMARY PRACTICE LOCATION: DEA # FOR THIS LOCATION: [redacted] 11/30/05

Street Address				City/State/Zip Code			
1331 N. 7TH STREET #225				PHOENIX AZ 85006			
Phone Number				**Fax Number**		**E Mail**	
602-553-0440				602-462-5588		N/A.	
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: [redacted] 11/30/06

Street Address				City/State/Zip Code			
2525 S. RURAL RD #65				TEMPE, AZ 85282			
Phone Number				**Fax Number**		**E Mail**	
602-553-0440				602-462-5588		N/A	
Schedule II Drugs	Y	Schedule III Drugs	X	Prescription-Only Drugs	X	Nubain	X
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices	X		

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

Physician's Signature: Paul Isaacson MD Date: 6/30/04

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

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

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

ADDITIONAL PRACTICE LOCATION: DEA # FOR THIS LOCATION:

ARIZONA MEDICAL BOARD

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

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: PAUL A. ISAACSON, MD

LICENSE #: AZ 23227 CL 6847

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

PLEASE NOTE

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

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

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

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

PRIMARY PRACTICE LOCATION:

1331 N. 7TH STREET #225 PHOENIX AZ 85006 602-953-0440
Street Address City, State, Zip Code Phone #

[redacted] 10-18-2005 11-30-2008 ✓
DEA # for this location (Attach Copy of DEA) Issued Date Expiration Date

ADDITIONAL PRACTICE LOCATION:

N/A.
Street Address City, State, Zip Code Phone #

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

Physician's Signature: _____ Date: 5/31/08.

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 JUN - 2 2008

9315

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2701 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

RECEIVED
JUN 30 2009
AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Paul Allen Isaacson, MD

MD LICENSE #: 23227 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

[redacted]

1331 N 7th Street #225
Phoenix, AZ 85006

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

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

Physician's Signature: [signature] Date: 6/27/09

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2701 . Fax (480) 551-2796
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Paul Allen Isaacson, MD

MD LICENSE #: 23227

SPECIALTY: GYNECOLOGY

RECEIVED

AZ MEDICAL BOARD

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

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

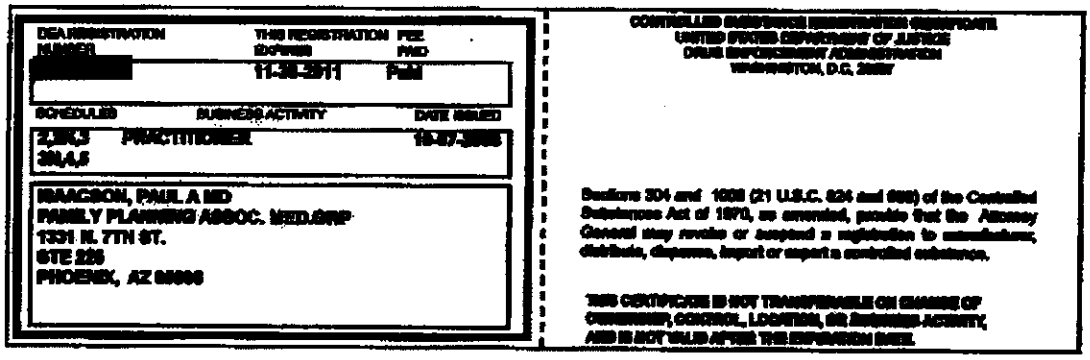
[redacted]

1331 N 7th Street #225
Phoenix, AZ 85006

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

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

Physician's Signature: _____ Date: 5/23/2010



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

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	10-07-2009

IBRAGIMOV, PAUL A MD
FAMILY PLANNING ASSOC. MED.SRP
1331 N. 7TH ST.
STE 225
PHOENIX, AZ 85006

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 manufacture, 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]	11-30-2011	Paid

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	10-07-2009

IBRAGIMOV, PAUL A MD
FAMILY PLANNING ASSOC. MED.SRP
1331 N. 7TH ST.
STE 225
PHOENIX, AZ 85006

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) 551-2704
Website: www.azmd.gov

RECEIVED
JUN 14 2011
AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Paul Allen Isaacson, MD

MD LICENSE #: 23227

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.

1331 N 7th Street #225
Phoenix, AZ 85006

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

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

Physician's Signature: _____ Date: 6/8/11

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

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	10-07-2008

ISAACSON, PAUL A MD
FAMILY PLANNING ASSOC. MED.GRP
1331 N. 7TH ST.
STE 235
PHOENIX, AZ 85006

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 manufacture, 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]	11-30-2011	Paid

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	10-07-2008

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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
2003 BIENNIAL MD LICENSE RENEWAL APPLICATION

6923

AZ MD Lic#: 23227 Paul A. Isaacson, MD **Renewal Fee: $450** **$800 (if postmarked after 05/16/2003)**

CURRENT INFORMATION: Please review and make corrections as necessary

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER	OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
1450 S Dobson Rd Ste B-220 Mesa AZ 85202-4712	
Phone #: (480) 461-1161 Fax #: E-Mail:	Phone #: Fax #: E-Mail:
MAILING ADDRESS [redacted]	MAILING ADDRESS
HOME ADDRESS [redacted]	HOME ADDRESS
Phone #: [redacted] Fax #: E-Mail:	Phone #: Fax #: E-Mail: Cell Phone #: (Optional)

RECEIVED
MAR 11 2003
BY

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

	Certified?	Practicing?
OBG	Y	Y

Make corrections if necessary

	Certified?	Practicing?

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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

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

PLEASE ANSWER THE FOLLOWING QUESTIONS:

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

If the answer is "yes" to any of the above questions, please provide a complete explanation and documentation. If documentation is requested, please include: the case number, venue, plaintiff name, and attorney names/addresses/phone numbers.

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

Signature of Licensee (Signature stamp will not be accepted) — Date: 3/7/03

[redacted]

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

ARIZONA MEDICAL BOARD
2005 BIENNIAL MD LICENSE RENEWAL APPLICATION

5202

AZ MD Lic#: 23227 Paul A. Isaacson, MD **Renewal Fee: $500** **$850** (If postmarked after 05/16/2005)

PUBLIC ADDRESS & PHONE NUMBER
1331 N 7th St Ste 225
Phoenix AZ 85006-2768

Phone #: (602) 553-0440 **Fax #:** (602) 462-5588
E-Mail:

MAILING ADDRESS
1331 N 7th St Ste 225
Phoenix AZ 85006-2768

HOME ADDRESS
[redacted]

Phone #: [redacted] **Fax #:** [redacted]
E-Mail:

RECEIVED
MAR 4 2005

OFFICE ADDRESS

Phone #: **Fax #:**
E-Mail:

MAILING ADDRESS

HOME ADDRESS

Phone #: **Fax #:**
E-Mail:
Cell Phone #: (Optional)

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

	Certified?	Practicing?
OBG	Y	Y

Make corrections if necessary

	Certified?	Practicing?

REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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

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

PLEASE ANSWER THE FOLLOWING QUESTIONS:

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

If the answer is "yes" to any of the above questions, please provide complete information [illegible] If the complaint is being reported, please include a copy of the complaint and [illegible]

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

Paul A. Isaacson
Signature of Licensee (Signature stamp will not be accepted)

3/1/05
Date

[redacted]

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

ARIZONA MEDICAL BOARD
2007 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 23227 Paul A. Isaacson, MD — **Renewal Fee: $500 $850 (if postmarked after 05/16/2007)**

CURRENT INFORMATION Please review and make corrections as necessary ™	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER 1331 N 7th St Ste 225 Phoenix AZ 85006-2768	OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
Phone #: (602) 553-0440 Fax #: (602) 462-5588 E-Mail:	Phone #: Fax #: E-Mail: [redacted]
MAILING ADDRESS 1331 N 7th St Ste 225 Phoenix AZ 85006-2768	MAILING ADDRESS
HOME ADDRESS [redacted]	HOME ADDRESS [redacted]
Phone #: [redacted] Fax #: [redacted] E-Mail: Mobile #:	Phone #: Fax # E-Mail: Mobile #: (Optional)

RECEIVED
APR 19 2007
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

	Certified?	Practicing?			Certified?	Practicing?	Expiration Date	Initials Required
OBG	Y	Y	Make corrections if necessary INITIALS REQUIRED		Y	Y	10/07	PI
PI	PI	PI			PI	PI	PI	PI

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

REQUEST FOR CHANGE IN LICENSE STATUS:

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

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

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

Paul A. Isaacson 4/17/06

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

23227 Paul A. Isaacson, MD

SCREENED AND ENTERED

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.

Individual - Paul Allen Isaacson

Licensee	License Type	Status	Status Date	Renew By	Expires	Orig Issue
23227	MD License	Active	03/31/2011	04/16/2013	08/16/2013	06/16/1995
	MD Dispensing Registration	Active	06/29/2011	06/30/2012		

Incomplete Tasks

Date Due	Task Type

Unpaid Invoices

Invoice Type	Due

Type	03 MD Professional Conduct Task		
Status	Complete		
Start Date	02/17/2009		
End Date	04/20/2009		
**********			
1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	No	If Yes, describe	
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	No	If Yes, describe	
3. Since your last renewal have you voluntarily surrendered any healthcare license?	No	If Yes, describe	
4. Since your last renewal have you had any healthcare license revoked?	No	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	No	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
**********			
Signature	Yes		
Notarized			
##########		Reviewed (If Yes Answers)	☐

Individual - Paul Allen Isaacson

License#	License Type	Status	Status Date	Renew By	Expires	Orig Issue
23227	MD License	Active	03/31/2011	04/16/2013	08/16/2013	06/16/1995
	MD Dispensing Registration	Active	06/29/2011	06/30/2012		

Incomplete Tasks

Date Due	Task Type

Unpaid Invoices

Invoice Type	Due

Type	04 Mental Health Task
Status	Complete
Start Date	02/17/2009
End Date	04/20/2009

****

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] If Yes, describe [redacted]

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 [redacted] If Yes, describe [redacted]

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] If Yes, describe [redacted]

****

Reviewed (If Yes Answers) [redacted]

Individual - Paul Allen Isaacson

License	License Type	Status	Status Date	Renew By	Expires	Orig Issue
23227	MD License	Active	03/31/2011	04/16/2013	08/16/2013	06/16/1995
	MD Dispensing Registration	Active	06/29/2011	06/30/2012		

Incomplete Tasks

Date Due	Task Type

Unpaid Invoices

Invoice Type	Due

Type	03 MD Professional Conduct Task		
Status	Complete		
Start Date	02/14/2011		
End Date	03/31/2011		
**********			
1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	No	If Yes, describe	
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	No	If Yes, describe	
3. Since your last renewal have you voluntarily surrendered any healthcare license?	No	If Yes, describe	
4. Since your last renewal have you had any healthcare license revoked?	No	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	No	If Yes, describe	
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	If Yes, describe	
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	If Yes, describe	
**********			
Signature	Yes		
Notarized			
##########		Reviewed (if Yes Answers)	☐

Individual - Paul Allen Isaacson

License#	License Type	Status	Status Date	Renew By	Expires	Orig Issue
23227	MD License	Active	03/31/2011	04/16/2013	08/16/2013	06/16/1995
	MD Dispensing Registration	Active	06/29/2011	06/30/2012		

Incomplete Tasks

Date Due	Task Type

Unpaid Invoices

Invoice Type	Due

Type 04 Mental Health Task

Status: Complete

Start Date: 02/14/2011

End Date: 03/31/2011

****

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] If Yes, describe [redacted]

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 [redacted] If Yes, describe [redacted]

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] If Yes, describe [redacted]

****

Reviewed (If Yes Answers) [redacted]