Arizona State Board of Medical Examiners
P.O. Box 6200, Scottsdale, Arizona 85261-6200
Home Page: http://www.bomex.org
Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

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

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type photos are not acceptable.

FOR BOARD USE
DO NOT USE THIS SPACE

Date Application Sent:_____

RECEIVED
FEB 19 2002

Date Application Received:_____

☐ ENDORSEMENT
☐ USMLE
☐ SPEX

13912

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

INFORMATION

All candidates shall provide satisfactory evidence that he/she:

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

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 Applications not fully complete within one year from date of notification of deficiency in application are considered withdrawn.

APPLICATION INSTRUCTIONS
(Read Carefully)

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

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

UNITED STATES OR CANADIAN MEDICAL SCHOOL GRADUATES and GRADUATES OF MEDICAL SCHOOLS LOCATED OUTSIDE THE UNITED STATES OR CANADA will forward the designated forms to the appropriate agency with the request that they be completed and returned *direct* to the Arizona Board of Medical Examiners.

APPLICATION and Initial Registration

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

1. Present Legal Name Lotke Pamela Susan
   (Last) (First) (Middle) (Maiden)

   (a) Other names used: _____

2. Office Address: 1250 Hancock St Quincy, MA 02169 (617)774-0966 (until 2/28/02)
   (No.) (Street) (City) (State) (Zip/Post Code) (Area code/Phone)

3. City and State 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 5/00 approved 206654
   (State Board) (Date of Application) (Result) (Certificate No.)

   Expires 10/4/2002 (renewed 10/00)
   (Date Issued) (Specify if by Written Examination or on Credentials)

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

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

Please answer questions on line at right.

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

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

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

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

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

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

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

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

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

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

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

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

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

21. Name and location of Medical School: University of Pennsylvania School of Medicine Phila, PA

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

Beth Israel Deaconess Medical Center 06/6yr residency 6/96 – 6/00

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

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

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

At Boston (City) MA (State) from 8/00 to present

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

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

The applicant Pamela S Lotke
(PRINT OR TYPE YOUR NAME AS YOU WISH IT TO APPEAR ON YOUR MEDICAL LICENSE)

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

Signature of Applicant _____, M.D.

STATE OF Mass.

County of Norfolk

(NOTARY SEAL)

Subscribed and sworn to before me this 14 day of Feb 20 02

Notary Signature _____ My Comission expires 5-10-2007
(NOTARY PUBLIC)

FOR OFFICIAL USE ONLY

Application Processed by dj 3-18-02

Application Checked by bd 3-18-02

Application Approved 4/22 20 02 By _____

License Issued ma 6/28/02

License Number 30503

Arizona Board of Medical Examiners
P.O. Box 6200
Scottsdale, Arizona 85261-6200
Phone: 480-551-2700 Fax: 480-551-2704
http://www.bomex.org

Form 2
Medical College Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the medical school granting the medical degree. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECT to the Arizona State Board of Medical Examiners, P.O. Box 6200, Scottsdale, Arizona 85261-6200. Your prompt response will be appreciated.

Name: Pamela S Lotke, M.D.

Signature 2/12/02 Date (Month/Day/Year)

(DO NOT DETACH)

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

This is to certify that Pamela S. Lotke (Full name of student.)

was granted the degree of medicine

by University of Pennsylvania (Full name of School or College of Medicine as it appears on the Applicant's Medical degree diploma.) on May 21, 1996 Date (Month/Day/Year)

that the date of his/her matriculation in medical school was September 3, 1991, and that he/she attended 40.87 (number) full courses of medical lectures comprising 40.87 (number) months.

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

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

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

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

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

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

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

Signed: Helene W Weinbach, M.D. (Seal of College)

Dean
President
Secretary
Registrar

University of Pennsylvania
School of Medicine
3450 Hamilton Walk
Suite 100, Stemmler Hall
Philadelphia, PA 19104-6087

Address: _____

20th Date: February, 2002 (Month/Day)

FEB 25 2002

s:\licensingwebforms\medical college certification.doc Revised 7/6/2000 dbl

Arizona Board of Medical Examiners
P.O. Box 6200
Scottsdale, Arizona 85261-6200
Phone: 480-551-2700 Fax: 480-551-2704
http://www.bomex.org

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MAR 18 2002

Form 3
Postgraduate Training Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECT** to the Arizona State Board of Medical Examiners, P.O. Box 6200, Scottsdale, Arizona 85261-8200. Your prompt response will be appreciated.

Name: Pamela S Lohle M.D.

Signature Pam Lohle 2/12/02 Date (Month/Day/Year)

(DO NOT DETACH)

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

✓ This is to certify that Pam Lohle, M.D. undertook and satisfactorily completed a full term approved program of 48 (number) months in the Beth Israel Deaconess Med Ctr. (Full name and complete address of Hospital)

in the field of Obgyn from: 7/1/96 (Date) (Mo/Day/Yr) to 6/2000 (Date/Anticipated Date)

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

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

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

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

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

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

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

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

Signed: [signature] M.D. FEB 26 2002 (Seal of Hospital)

Title: Residency Program Director

Address: 330 Brookline Ave Date: 2/21/02

USMLE
United States Medical Licensing Examination

United States Medical Licensing Examination
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 07/26/2002

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

Examinee: Yoder, Patricia Susan
USMLE ID#: [redacted]
DOB: [redacted]

Results for all Steps taken by this examinee (and for which results have been reported to the FSMB) are listed below. For Step 3, the test date reflects the day on which the examination began. Scores are reported on two scales: the three-digit scale and the two-digit scale. The passing score ("Passing") on each scale is shown in parentheses.

STEP 1	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	6/8/1993	PASS	225	(176)	89	(75)	

STEP 2	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	8/31/1994	PASS	226	(167)	87	(75)	

STEP 3	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
MASSACHUSETTS	5/15/1997	PASS	217	(177)	87	(75)	

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

CRT 3.02.01 8343511

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE

ARIZONA STATE BOARD OF MEDICAL EXAMINERS
2002 BIENNIAL MD LICENSE RENEWAL APPLICATION

105

AZ MD Lic#: 30503 Pamela S. Lotke, MD Renewal Fee: $450 $800 if postmarked after 11/04/2002

[redacted]

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

[redacted]

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

[redacted]

[redacted]

RECEIVED
SEP 23 2002
By

[redacted]

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

[redacted]

Phone #: [redacted] Fax #:
E-Mail:
Cell Phone #: [redacted] (Optional)

[redacted]

Select from the attached list of Self-Designated "Field of Practice" Codes

	Certified?	Practicing?
OBG	N	N

Make corrections if necessary

	Certified?	Practicing?
	eligible	yes

[redacted]

☐ **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 proceeding 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, BOMEX 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 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.

[redacted]

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 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 matter resulted in a settlement or judgment against you? ☐ Yes ☒ No

[redacted]

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2000 and 2001, 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.

Pam Lotke
Signature of Licensee (Signature stamp will not be accepted)

9/12/02
Date

[redacted]

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

ARIZONA MEDICAL BOARD
2004 BIENNIAL MD LICENSE RENEWAL APPLICATION

442

AZ MD Lic#: 30503 Pamela S. Lotke, MD — Renewal Fee: $500 — $850 (if postmarked after 11/04/2004)

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

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

MAILING ADDRESS
[redacted]

HOME ADDRESS
[redacted]

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

RECEIVED
AUG 23 2004
By

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
UMC - Dept of OB/GYN
1501 N. Campbell
Tucson AZ 85724

Phone #: 520-626-6591 Fax #:
E-Mail: [redacted]
MAILING ADDRESS
[redacted]

HOME ADDRESS
same

Phone #: Fax #:
E-Mail:
Cell Phone #: [redacted] (Optional)

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

	Certified?	Practicing?
OBG	N	Y

Make corrections if necessary

	Certified?	Practicing?
OBG	Y	Y

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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

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

PLEASE ANSWER THE FOLLOWING QUESTIONS:

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

If the answer is "yes" to any of the above questions, please provide documentation regarding the [redacted] reported, please include: a copy of the complaint and consent agreement.

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2002 and 2003, 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: 8/19/04

[redacted]

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

ARIZONA MEDICAL BOARD
2006 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 30503 Pamela S. Lotke, MD

Renewal Fee: $500 / $850 (if postmarked after 11/04/2006)

PUBLIC ADDRESS & PHONE NUMBER

U M C Dept. of Obstetrics & Gynecology
1501 N Campbell
Tucson AZ 85724-0001

Phone #: (520) 907-2251 Fax #:

E-Mail: [redacted]

OFFICE ADDRESS

Phone #: (520) 626-6591 Fax #: (520) 874-4801

E-Mail:

RESIDENCE ADDRESS

[redacted]

RECEIVED BY:
AUG 0 8 2006
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

Phone #: [redacted] Fax #:

E-Mail: [redacted]

Mobile #:

MAILING ADDRESS

HOME ADDRESS

Phone #: Fax #:

E-Mail:

Mobile #: [redacted] (Optional)

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND EXPIRATION DATE

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

	Certified?	Practicing?
OBG	Y	Y

Make corrections if necessary
INITIALS REQUIRED

	Certified?	Practicing?	Expiration Date	Initials Required
			12/31/08	PSL

If the above fields are not verified by your initials the ABMS certification will be removed from your profile on the website.

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

☐ INACTIVE STATUS: Please inactivate my Arizona license. My signature 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 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.

CONTINUED ON BACK →

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. Other than Arizona have you 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 ☒
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. Other than Arizona 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 ☒
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",*** the physician 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, the applicant must submit photocopies of any corresponding documents, such as patient records, 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.

QUESTIONS CONTINUED ON NEXT PAGE

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? 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 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. This 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 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.
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.

I hereby certify, under penalty of perjury, I am a U.S. Citizen or a qualified/registered alien and that all information on this form is currently accurate. I also certify that during calendar years 2004 and 2005, 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: 8/7/06

30503 Pamela S. Lotke, MD

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 30503

Renewal Fee plus late fee (if postmarked 30 days after due date)

NAME: Patricia Lock

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
PUBLIC ADDRESS & PHONE NUMBER
1501 N. Campbell Ave
PO Box 245078
TUCSON, AZ 85724-3078

Phone #: 520-626-4591 Fax #: 520-626-2514
E-Mail:

MAILING ADDRESS
same as above

HOME ADDRESS
[redacted]

AUG 1 8 2008

Phone #:
Mobile #:

Required *

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 certificate)
OBG	yes	yes	12/08 - 2 years recert

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 correctly answered 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.)

Signature of Licensee (signature stamp will not be accepted) 8/13/08 Date

AUG 18 2008

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.

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Name: Pamela Slotke License Number: 30503

Signature: _____

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]	[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?**		

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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.

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

Name: Pamela S. Lotke License Number: 30503

Signature: [signature] PAGE 3

Individual - Pamela Susan Lotke

2010 Renewal

License#	License Type
30503	MD License

****

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

****

Individual - Pamela Susan Lotke

2010 Renewal

License#	License Type
30503	MD License

****

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]

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