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

December 7, 2011

RE: Public Information Request regarding Gabrielle Goodrick, M.D.

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 note the money order #14-403424045 is being returned to you as the requested documents were paid for with money order #19183188295.

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 12/07/11 @ 09:08

General Information

Gabrielle J. Goodrick MD
4141 N. 32nd St., Suite 105
Phoenix AZ 85018
Phone: (602) 279-2337

License Number: 22811
License Status: Active with Restrictions
Licensed Date: 01/01/1995
License Renewed: 05/23/2011
Due to Renew By: 05/23/2013
If not Renewed, License Expires: 09/23/2013

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:	UNIV OF VT COLL OF MED Burlington, Vermont
Graduation Date:	05/22/1993
Residency:	07/01/1993 - 06/30/1996 (Family Practice) PHOENIX BAPTIST HOSPITAL MEDICAL CENTER PHOENIX , AZ
Area of Interest	Family Medicine (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

02/10/2011 Practice Restriction - Practice Restriction Amended - See Amended Order

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

2001 West Camelback Road, Suite 300
Phoenix, Arizona 85015
A.C. (602) 255-3751

MAY 0 4 1994

ARIZONA BOARD OF MEDICAL EXAMINERS
1651 E. Morten Ave. / Ste. 210
Phoenix, Arizona 85020

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE THROUGH ENDORSEMENT

FOR BOARD USE
DO NOT USE THIS SPACE

BOARD

JUL 1 1 1994

LETED 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: GOODRICK (Last) GABRIELLE (First) JULIE (Middle) _____ (Maiden)
   PRINT OR TYPE
   (a) Other names used: _____ Social Security No. [redacted]
2. Address: Residence: [redacted] (No.) (Street) (City) (State) (Zip Code) (Phone)
   Office 6025 N. 20th Ave (No.) (Street) Phoenix (City) AZ (State) 85015 (Zip Code) (602)246-5525 (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) California (Specify State Board) 12/93 (Date of Application) Pending completion of PGY 1 (Result) _____ (Certificate No.)
   _____ (Date Issued) _____ (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]

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]

(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 5'8" weight 150lb color of eyes Green 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: Phoenix Baptist Hospital 7/93 - present

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 Phoenix (City) AZ (State) from 7/93 to 6/94 (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? Phoenix Baptist Hospital
Solo or in Association with? Residency

24. What is your intended specialty practice? Family Practice

25. What branch of the United States Armed Forces have you served with, if any, including USPHS? N/A
Active duty? From _____ (Month and Year) to _____ (Month and Year)

The applicant Gabrielle Julie Goodrick
(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 Gabrielle J Goodrick, M.D.

STATE OF Arizona
County of Maricopa } ss

(NOTARIAL SEAL)

Subscribed and sworn to before me this 29th day of June 19 94

Notary Signature Dina Lee Brummer (Notary Public) My Commission expires 5-10-95

FOR OFFICE USE ONLY

Application Rec'd	19	Application Processed by	MA
Application Completed	19	Application Checked by	bd
Form No. I Rec'd	6-3- 19 94	Application Approved	11-29 19 94
Form No. II Rec'd	6 scores 4/29 19 94	By	Becky Drew
Form No. III Rec'd	6-27- 19 94	License Issued	January 1, 19 95
Form No. III Rec'd	11-11 19 94	License No.	22811
Form No. III-A Rec'd	na 19		
Form No. IV Rec'd	na 19		
Investigation Completed	19		

Application withdrawn _____ (Date)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

SATISFACTION OF REQUIREMENTS SUMMARY

ENDORSEMENT

APPLICATION Received July 11, 1994

NAME IN FULL GOODRICK (Last) GABRIELLE (First) JULIE (Middle)

Current Address [redacted]

Telephone [redacted] (Residence) 246-5525 (Office)

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

CITIZENSHIP Check One: ☒ Native ☐ Naturalized Declared Intention On

MEDICAL EDUCATION The University of Vermont College of Medicine, Burlington, VT 050-02 (Full Name and Location of Medical School)

M.D. Awarded: May 22, 1993 Proof Received: June 3, 1994 ☒ Approved

ECFMG Certificate No. Dated: Proof Received:

FORM III/photo
Res. Reg.
Fees pd
POSTGRADUATE TRAINING

In FP (Field of Training) for 16 months at Phoenix Baptist Hospital Phoenix, AZ (Name of Institution)
From July 1, 1993 to Date '94 (will complete 6/30/96)

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 FP (Current)

FORM II

SPEX EXAM: DATE: SCORE: PROOF REC'D

Endorsement through FLEX-California ; No. (Certificate) ; Issued December 1993 W/E (Date)

LICENSES

California #A053323 7/27/94 ; [ ] W/E [X] 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

In ; [ ] W/E [ ] FLEX [ ] Recip. With

(TUMBLE)

U.S. MILITARY OR PUBLIC HEALTH SERVICE	Served in None (Branch)	From to
	Honorable Discharge Received	Discharge Rank
PREVIOUS PRACTICE	In Phoenix (internship/residency) AZ	From July 1, 1993 to Date 19 94
	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 # A 058993
INVESTIGATION	AMA Approval 6/13/94, Record Clear, N/D	
	Fed. State Board Approval 6/2/94, Record Clear, N/D	
	California Board Approval Photo 11/11/94, Cert.#A053323, Iss.7/27/94, FLEX, Current, 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	Phoenix (residency)	

ms 11/7/94 11/29/94 bd.

[redacted]

ARIZONA BOARD OF MEDICAL EXAMINERS

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

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN'S NAME: Goodrick (Last Name) Gabrielle (First Name) J (MI)

LICENSE NUMBER: 22811 SPECIALTY: FP

CHECK ONE: Initial Application: ✓ Renewal Application: _____

Please list below ALL locations where you will be dispensing controlled substances and prescription-only medications. For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.

PRIMARY PRACTICE LOCATION:

Street Address:				City/State/Zip Code:			
7500 N. Dreamy Draw Dr. #133				Phx, Az 85020			
Schedule II		Schedule III		Schedule IV		Schedule V	
Nubain		Stadol		Prescription-Only Drugs	X	Prescription Devices	

ADDITIONAL PRACTICE LOCATIONS:

Street Address:				City/State/Zip Code:			
5651 N 7th St.				Phx, Az 85014			
Schedule II		Schedule III		Schedule IV		Schedule V	
Nubain		Stadol		Prescription-Only Drugs	X	Prescription Devices	

Street Address:				City/State/Zip Code:			
Schedule II		Schedule III		Schedule IV		Schedule V	
Nubain		Stadol		Prescription-Only Drugs		Prescription Devices	

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

With this registration form, include a photo copy of your current Drug Enforcement Administration (DEA) Certificate of Registration for each dispensing location where controlled substances will be maintained and/or dispensed. Return your completed registration form and certificate(s) to ATTENTION: Dispensing Physician Registration at the address listed on the top of this application form.

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

☒ Form Completed ☒ DEA Certificate(s) Enclosed ☒ Fee of $ 200. enclosed

Physician's Signature: Gabrielle Goodrick Date: 12-3-96

RECEIVED B.O.M.E.X.

DEC 30 96

BM953280007 (01/96)

ADDITIONAL PRACTICE LOCATIONS:

Street Address:				City/State/Zip Code:			
Schedule II		Schedule III		Schedule IV		Schedule V	
Nubain		Stadol		Prescription-Only Drugs		Prescription Devices	

Street Address:				City/State/Zip Code:			
Schedule II		Schedule III		Schedule IV		Schedule V	
Nubain		Stadol		Prescription-Only Drugs		Prescription Devices	

Street Address:				City/State/Zip Code:			
Schedule II		Schedule III		Schedule IV		Schedule V	
Nubain		Stadol		Prescription-Only Drugs		Prescription Devices	

Street Address:				City/State/Zip Code:			
Schedule II		Schedule III		Schedule IV		Schedule V	
Nubain		Stadol		Prescription-Only Drugs		Prescription Devices	

Street Address:				City/State/Zip Code:			
Schedule II		Schedule III		Schedule IV		Schedule V	
Nubain		Stadol		Prescription-Only Drugs		Prescription Devices	

Street Address:				City/State/Zip Code:			
Schedule II		Schedule III		Schedule IV		Schedule V	
Nubain		Stadol		Prescription-Only Drugs		Prescription Devices	

For Business Office Staff Use Only

Check No.: 90697 Date Received: 12/30/96 Batch No.: 076901 By: Ol

BM953280007 (01/96)

ARIZONA BOARD OF MEDICAL EXAMINERS

January 1, 1995

Gabrielle Julie Goodrick, MD
[redacted]

Dear Dr. Goodrick:

Congratulations! Your certificate to practice medicine in the State of Arizona, License No. 22811, issued on January 1, 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 /bd

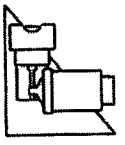
Elaine Hugunin
Deputy Director

12/94

Enclosures

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

Azmacort® Oral Inhaler
(triamcinolone acetonide)



11-30-94

To whom it may concern,
Please withhold issuance of my AZ license until after Jan 1, 1995.

Thank you.

Gabrielle Goodrich MD

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

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

READ CAREFULLY - THIS CAN SAVE YOU MONEY

DATE: November 29, 1994

TO: Gabrielle Julie Goodrick, MD
[redacted]

RE: LICENSE THROUGH ENDORSEMENT

Dear Doctor:

The Board of Medical Examiners, State of Arizona, following review of your application and credentials for a license to practice medicine in Arizona has been approved.

Arizona 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 Arizona Board of Medical Examiners, 1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020. The card must be in hand by Thursday of each week in order for your license to be issued the following day. DO NOT COMMENCE PRACTICE IN ARIZONA UNTIL A LICENSE NUMBER HAS BEEN ASSIGNED.

PLEASE NOTE: Arizona statues further provide that each licentiate is required to renew such registration on January 1 of each year which can amount to a tidy sum. If you want to SAVE MONEY and you are NOT planning to practice medicine in Arizona until AFTER JANUARY 1, 1995 the enclosed card can be submitted now WITH YOUR WRITTEN INSTRUCTIONS TO WITHHOLD ISSUANCE OF A LICENSE UNTIL AFTER JANUARY 1, 1995. No license number will be assigned until the actual issuance of the license.

The Board publishes an annual directory of all its licentiates, which is distributed about October of each year. The 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. If you anticipate a move before that date, please indicate your new address(es) with effective date as well as your current address(es).

Cordially,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Becky Drew

Becky Drew
Licensing Technician

Enc. 3

Department of
Consumer
Affairs

The Medical Board of California

Certifies that

Gabrielle Julie Goodrick

a graduate of

University of Vermont College of Medicine

having shown to the satisfaction of the Board that he possesses the qualifications required by the Medical Practice Act and having successfully passed a written examination recognized by this Board as to his qualifications is hereby authorized to engage in the practice of medicine and surgery and is hereby granted a

Physician's and Surgeon's Certificate

in this State

In Testimony Whereof, *THE MEDICAL BOARD OF CALIFORNIA has issued this CERTIFICATE and caused the same to be signed by its PRESIDENT and SECRETARY and its SEAL to be hereto affixed this 27th day of July, A.D. 1994.*

The Medical Board of California

Robert Del Junco M.D.
President, Division of Licensing

Raymond H Mallet
Secretary, Division of Licensing

E. K
NOV 1 1 1994

No. A 053323
Audit No. 94-02015

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

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

November 7, 1994

Gabrielle J. Goodrick, M.D.
[redacted]

RE: License through Endorsement

Dear Doctor:

This will acknowledge receipt of your application for a license to practice medicine in Arizona through Endorsement.

Our receipt number: A 058993 covering your fee deposit of $ 450.00 is enclosed, with a schedule of examination dates and filing deadlines, if applicable.

To complete our processing of your application, we need to receive the following:

FORM III Postgraduate Training Certification from Phoenix Baptist Hospital, Phoenix, AZ for the period July 1, 1994 to anticipated date of completion. (form enclosed) 11/n/94

At the time of your application, you indicated California license pending. If this license has been issued, please provide this Board will a photocopy. Please advise 11/11/94

NOTE: FINAL ACTION ON YOUR APPLICATION CANNOT BE TAKEN UNTIL THESE RESPONSES ARE IN YOUR FILE OF RECORD WHICH IS YOUR RESPONSIBILITY. PLEASE BE ADVISED THAT APPLICATIONS NOT FULLY COMPLETED WITHIN ONE YEAR FROM THIS DATE, INCLUDING PARTICIPATION IN WRITTEN (SPEX/USMLE) EXAMINATIONS, IF APPLICABLE, ARE CONSIDERED WITHDRAWN.

Your application is being processed routinely and you will be advised in due course as to the Board's decision relative to the granting of an Arizona license.

Cordially,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Marie Slaughter
Licensing Technician

Enc. 2

revised 9/94

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: May 15, 1994

RECEIVED
MAY 26 1994

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

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

NAME: GOODRICK (LAST) GABRIELLE (FIRST) JULIE (MIDDLE)

ADDRESS: [redacted]

City, State and Zip

Date of Birth

Social Security Number

University of Vermont College of Medicine
Medical School of Graduation and Branch Location

May 22, 1993
Date of Graduation

Please mail the response to the following:

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

Gabrielle Julie Goodrich
Signature

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAY 26 1994

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

JUN 2 1994

APR 1 1 1994

Goodrick Gabrielle

(FOR OFFICE USE ONLY)

PRELIMINARY 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: GABRIELLE (FIRST) JULIE (MIDDLE) GOODRICK (LAST)

Current Office Address: 6025 N. 20th Ave, Family Med Ctr.

Area Code: 602

City: Phoenix State: AZ Zip Code: 85015 Phone: 246-5525

Current Residence Address: [redacted]

Area Code: [redacted]

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

4-19-94

MEDICAL SCHOOL: Name: University of Vermont 050-02

City and State: BURLINGTON, VERMONT Date of Degree: 5/93

If transferred from other medical school, please indicate name: N/A

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

5TH PATHWAY PROGRAM: U.S. Medical School: N/A

HOSPITAL: _____ City: _____ State: _____

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

Key envelope

INTERNSHIP: (List U.S. & Canadian only) **HOSPITAL:** Phoenix Baptist Hospital

6025 N. 20th Ave City: Phoenix State: AZ

Term: Started: 6/93 (MONTH AND YEAR) Completed: 6/94 (MONTH AND YEAR) FEES PAID

Sent

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

6025 N. 20th Avenue City: Phoenix State: AZ

Term: Started: TO START/ 7/94 (MONTH AND YEAR) Completed: _____ (MONTH AND YEAR)

Specialty Field: Family Practice

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

_____ City: _____ State: _____

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

Specialty Field: _____

FOR OFFICE USE ONLY

INFORMATION FORM FORWARDED _____ 19__

APPLICATION FORWARDED 4/19/94

BOMEX

APR 1 8 1994

RECIPROCITY EXAM

APPLICATION & FORMS I II III III-A IV

4/19 CMA FS

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

TEACHING HOSPITAL: N/A

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 _____ (date)	Step I _____ (date)	Comp. I 12/93 (date)
Part II _____ (date)	Step II _____ (date)	Comp. II 12/93 (date)
Part III _____ (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) N/A (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.: _____

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

PRACTICE: City & State Where You Now Practice: Phoenix, AZ (Intern)

Date Above Practice Was Established: 6/93

U.S. CITIZENSHIP:

(✓) 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 ✓

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

If "Yes", indicate State/ Province N/A

Reason for action and action taken: _____

(NOTE: Attach separate sheet, if necessary)

Have you ever been convicted of Medicare/ Medicaid fraud? Yes _____ No ✓

If "Yes", when? N/A

Where? _____

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

If "Yes", when? N/A

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 ✓

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

If "Yes", name and address of hospital(s) N/A

(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: Gabrielle Goodrich, M.D. DATE: 4/13/94

BOMEX

APR 18 1994

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

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: Gabrielle Julie Goodrick, M.D. Gabrielle Julie Goodrick, M.D.
(Please Print or Type) (Signature)

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

Date: _____

(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 Gabrielle Julie Goodrick, M.D. undertook and
(Name of Applicant in Full)

satisfactorily completed a full term approved program of 12 months in the: Phoenix Baptist Hospital
(Number) (Full Name and Complete Address of Hospital)

6025 North 20th Avenue, Phoenix, AZ 85015

in the field of Family Medicine from 7-1-93 to 6-30-94
(Date) (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 _____
Christopher Shearer, M.D.
Title Program Director

Address P.O. Box 11469 Phoenix, AZ 85061 JUN 27 1994

(SEAL OF HOSPITAL) [redacted]

Date 6-20-94

Revised 8/89

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: Phoenix Baptist Hospital

ADDRESS: 6025 N. 20th Ave Phoenix AZ 85015
City State Zip Code

DATE OF STAFF MEMBERSHIP: July 1993 to present

TYPE OF STAFF MEMBERSHIP: Resident in Family Practice

2) HOSPITAL: _____

ADDRESS: _____
City State Zip Code

DATE OF STAFF MEMBERSHIP: _____

TYPE OF STAFF MEMBERSHIP: _____

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: _____

6) MEDICAL AGENCY OF EMPLOYMENT: _____

RECEIVED B.O.M.E.X.
JUL

ADDRESS: _____
City State Zip Code

DATE OF EMPLOYMENT: _____

→ WARNING: ALTERATION, ADDITION OR MUTILATION OF ENTRIES IS PROHIBITED.
ANY UNOFFICIAL CHANGE WILL RENDER THIS PASSPORT INVALID.

NAME—NOM
GABRIELLE JULIE GOODRICK

SEX—SEXE
F

BIRTHPLACE—LIEU DE NAISSANCE
[redacted]

BIRTH DATE—DATE DE NAISSANCE
[redacted]

ISSUE DATE—DATE DE DELIVRANCE
APRIL 14, 1987

NATIONALITY—NATIONALITÉ
UNITED STATES OF AMERICA

EXPIRES ON—EXPIRE LE
APRIL 13, 1997

Gabrielle Julie Goodrick
—SIGNATURE OF BEARER—SIGNATURE DU TITULAIRE

—NOT VALID UNTIL SIGNED

The College of Medicine
of

The University of Vermont

To all to whom these presents may come, sendeth greetings

Whereas the Faculty of the College and the University Senate have recommended

Gabrielle Julie Goodrick, B.Sc.

as having completed the Studies assigned and passed the Examinations required, We, the Trustees of the University by virtue of the authority vested in us do hereby confer upon her the Degree of

Doctor of Medicine

and admit her to all the rights, privileges and honors appertaining thereto

In Witness Whereof, the seal of the University and the signature of the President the Dean and the Secretary are hereunto affixed.

Given at Burlington, Vermont on the twenty-second day of May in the year of our Lord, One Thousand Nine Hundred and Ninety-Three and of the University the Two Hundred and Second.

Secretary of the Board of Trustees

Dean

President of the University

This is an exact copy of the original diploma
Elizabeth S. Reinhardt
Notary Public

RECEIVED B.O.M.E.X.
JUL 11 94

PHOENIX BAPTIST
HOSPITAL & MEDICAL CENTER™

FAMILY PRACTICE RESIDENCY PROGRAM

THE BOARD OF DIRECTORS AND ADMINISTRATION OF
PHOENIX BAPTIST HOSPITAL AND MEDICAL CENTER
HEREBY CERTIFIES THAT

Gabrielle J. Goodrick, M.D.

Has successfully completed one year
in the Family Practice Residency Program
June 30, 1994

CHAIRMAN, BOARD OF DIRECTORS

PRESIDENT

EXECUTIVE VICE PRESIDENT

PROGRAM DIRECTOR

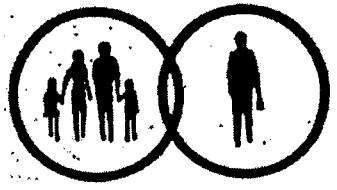


Photo on back

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: Gabrielle Julie Goodrick, M.D. (Please Print or Type) Gabrielle Julie Goodrick, M.D. (Signature)

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

Date: May 15, 1994

(DO NOT DETACH)

[redacted] 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 Gabrielle Goodrick, M.D. (Full Name of Student)

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

the University of Vermont College of Medicine (Full Name of School or College of Medicine as it appears on the Applicant's Medical degree diploma) on May 22, 1993,

that the date of his/her matriculation in medical school was August 14, 1989; and that he/she attended 4 (Number) full courses of medical lectures comprising 9½ (Number) months of 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 Marga Susan Sproul, M.D.

Dean / President / Secretary / Registrar of Marga Susan Sproul, M.D.
Associate Dean for Admissions & Student Affairs
the University of Vermont College of Medicine

(SEAL OF COLLEGE) [redacted]

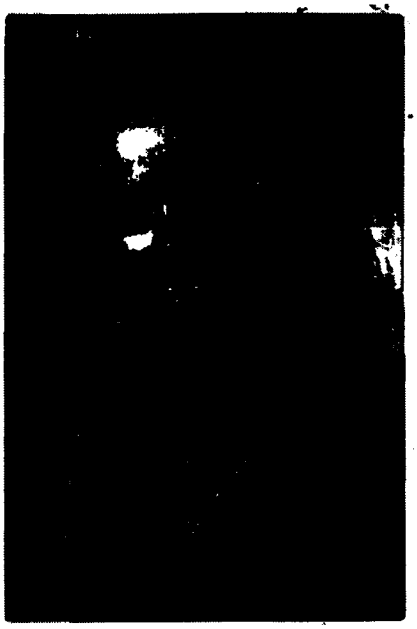
Date May 27, 1994

Address: Given Building, Burlington, Vermont 05405

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

JUN 3 1994

Revised 4/91



The applicant must assume the responsibility for completion of this form and is forewarned that it must be fully completed and forwarded to the Arizona Board of Medical Examiners before any application may be considered.

Mailed 6-24-94

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: Gabrielle Julie Goodrick, M.D. Gabrielle Julie Goodrick, M.D.
(Please Print or Type) (Signature)

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

Date: _____

(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 Gabrielle Julie Goodrick, M.D. undertook and
(Name of Applicant in Full)

satisfactorily completed a full term approved program of 12 months in the: Phoenix Baptist Hospital
(Number) (Full Name and Complete Address of Hospital)

6025 North 20th Avenue, Phoenix, AZ 85015

in the field of Family Medicine from 7-1-93 to 6-30-94
(Date) (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.

BOMEX

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.

NOV 10 1994

Signed _____ NOV 11 1994
Christopher Shearer, M.D.

Title Program Director

(SEAL OF HOSPITAL)
(So indicate, if none)

Address P.O. Box 11469 Phoenix, AZ 85061 Date 6-20, 1994

Revised 8/89

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: Gabrielle Goodrick, M.D. (Please Print or Type) Gabrielle Goodrick, M.D. (Signature)

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

Date: 11/8/94

(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 Gabrielle Julie Goodrick (Name of Applicant in Full), M.D. undertook and we anticipate satisfactorily completed a full term approved program of 24 (Number) months in the: Phoenix Baptist Hospital (Full Name and Complete Address of Hospital)

6025 North 20th Avenue, Phoenix, AZ 85015

in the field of Family Medicine from 7-1-94 (Date) to 6-30-96 (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.

FAX

Signed Christopher Sheaper, M.D. 1994

Title Program Director

Address P.O. Box 11469 Phoenix, AZ 85061

(SEAL OF HOSPITAL) (So indicate, if none)

Date 11-8-1994

Revised 8/89

The applicant must assume the responsibility for completion of this form and is forewarned that it must be fully completed and forwarded to the Arizona Board of Medical Examiners before any application may be considered.

#17433

PAID

COMPLETED

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

POSTGRADUATE TRAINING REGISTRATION
(Internship - Residency - Fellowship)

AND

UNITED STATES MEDICAL LICENSING EXAMINATION APPLICATION

Chapter Thirteen of Arizona Revised Statutes provides exemption from licensure of a person while participating in an approved hospital training program, provided (s)he complies with the applicable registration requirements of the chapter. The individual must register with the Board for each year of training, and supply the Board with proof of such training, and pay the registration fee.

I wish to register for and exemption from licensing because of my participation in an approved hospital internship, residency, or fellowship program. The fee of $20.00 is enclosed.

A SEPARATE FORM MUST BE COMPLETED FOR EACH YEAR OF POSTGRADUATE TRAINING

☐ I wish to register for the United States Medical Licensing Examination. Please send me the requirements for eligibility for the exam, as well as the application instructions and form and other required forms. Please mail it to the address I provide on this form.

☐ I wish to apply for licensure in Arizona by examination. Please send me the USMLE registration materials and license application materials and instructions.

☐ The following information must be completed by the applicant and the licensed hospital where the approved hospital training takes place. It must be submitted to the offices of the Board of Medical Examiners of the State of Arizona, 1651 East Morten, Suite 210, Phoenix, AZ 85020.

Name in full: GOODRICK (Last) GABRIELLE (First) JULIE (Middle)

Current complete address: [redacted] (Number and Street) (City) (State) (Zip)

City, County, State and Country of Birth: [redacted]

Full Name of Medical School(s) Attended: University of Vermont College of Medicin

Location(s) of Medical School(s): Burlington, Vermont

Exact Date of Diploma: May 22, 1993

Have you successfully completed the Examinations of the Education Counsel on Foreign Medical Graduates? N/A Standard Certificate Number N/A Date of Certificate _____

Have you ever previously been enrolled in an ACGME-approved residency program? Yes

List the names and locations of all previous residency programs Phoenix Baptist Hosp Family Practice Internship, Phoenix, AZ

Do you hold a current Arizona License? License Number N/A

In what other states have you applied for or received licensure? California

1. Have you ever had an application to practice medicine denied or rejected by any licensing body? No
2. Have any actions, restrictions, limitations (including probation or academic probation) been taken while you were participating in any type of training program or by any health care provider? No

(Complete Both Sides)

JUN 2

3. Have you ever been counseled regarding your performance or behavior in any training program or by any health care provider? No

4. Have you ever taken a leave of absence during medical school, training, or any other practice? No

5. Have you ever been charged with a violation of any law, statute, rule or regulation of any domestic or foreign governmental agency? NO

6. Have you ever been monitored for alcohol or drug use or mental illness by any Medical professional association or licensing body which either did or did not result in your being reported to a licensing agency? [redacted]

7. Do you have any disability which may affect your ability to safely engage in the practice of medicine? [redacted]

If the answer to any question One through Seven above is yes, please attach a written explanation.

Note: Postgraduate Training registration only allows an individual to function in an approved postgraduate training program. The practice of medicine outside such a setting, i.e. insurance physicals, signing documents with an "M.D." designation, etc. is a violation of law and may result in formal disciplinary action, the denial of license or both.

The applicant Gabrielle Julie Goodrick
(Name in full)
being forth duly sworn upon his oath deposes and says: that he 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 in this application, that the same was procured in the regular course of instruction and that it and all other credentials submitted were procured without fraud, deceit or misrepresentation or any mistake of which the applicant is aware.

Signature of Applicant Gabrielle Julie Goodrick Date 5/4/94

HOSPITAL CERTIFICATION

This is to certify that Gabrielle Julie Goodrick, M.D. is currently engaged in a hospital training program in the field of Family Medicine, at (name of hospital) Phoenix Baptist Hospital. The program commenced July 1, 1994 and the anticipated ending is June 30, 1995. The program certifies that it is accredited by the ACGME and certifies that the following statements are true and correct:

1. Have any actions, restrictions, limitations (including probation or academic probation) been taken while the applicant was participating in any the training program? No

2. Has the applicant ever been counseled regarding his/her performance or behavior in the training program? ND

3. Has the applicant ever taken a leave of absence during medical school, training, or any other practice? ND

4. Does the applicant have any disability which may affect his/her ability to safely engage in the practice of medicine? [redacted]

Name Signed [signature]
(Director/Dean of Medical Education
Name Printed Christopher Shearer, M.D.

SEAL OF HOSPITAL

Date May 20, 1994

Revised 3/94

(Complete Both Sides)

The Federation of State Medical Boards of the United States

INCORPORATED

6000 WESTERN PLACE, SUITE 707
FORT WORTH, TEXAS 76107-4618
(817) 735-8445

Goodrick Gabrielle

EXAMINEE: GABRIELLE JULIE GOODRICK

Douglas N. Cerf
Executive Director
Arizona State Board of Medical Examiners
1651 East Morten Avenue
Suite 210
Phoenix, AZ 85020

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

FIN: [redacted] Date of Certification: 04/28/94

DATE OF EXAM	STATE EXAM TAKEN FOR	STATE ID #	COMP 1	COMP 2
12/93	CALIFORNIA	00906	76	84

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

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

* *

Furthermore: A search of the Federation's Board Action Data Bank reveals no reported information on the above named physician.

msb

BOMEX

APR 29 1994

3302

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
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BY

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Gabrielle Goodrick

LICENSE #: 22811 SPECIALTY: Family Practice

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 obtained for EACH location where controlled substances will be dispensed and must be kept current during the registration period.

PRIMARY PRACTICE LOCATION: DEA # FOR THIS LOCATION:

Street Address				City/State/Zip Code			
5040 N 15th Ave #303				Phoenix AZ 85015			
Phone Number				Fax Number		E Mail	
602 279 2337				6022309025			
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: NA DEA # FOR THIS LOCATION:

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

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

Physician's Signature: [signature] Date: 4/25/03

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

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

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

ARIZONA MEDICAL BOARD

3806

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Home Page: http://www.azmdboard.org

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

RECEIVED
APR 09 2004

PHYSICIAN NAME: Gabrielle Julie Goodrick, MD

LICENSE #: 22811 **SPECIALTY:** Family Practice

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]

Street Address				City/State/Zip Code			
5040 N 15th Ave #303				Phoenix AZ 85015			
Phone Number				**Fax Number**		**E Mail**	
602 279-2337				602 2309025		NA	
Schedule II Drugs	✓	**Schedule III Drugs**	✓	**Prescription-Only Drugs**	✓	**Nubain**	✓
Schedule IV Drugs	✓	**Schedule V Drugs**	✓	**Prescription Devices**	✓		

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

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

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

Physician's Signature: [signature] **Date:** 3/27/04

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

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

ARIZONA MEDICAL BOARD

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DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Gabrielle Goodrick, MD

LICENSE #: 22811 **SPECIALTY:** Family Practice

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] 9/30/06

Street Address				City/State/Zip Code			
5040 N 15th Ave #303				Phoenix AZ 85015			
Phone Number				**Fax Number**		**E Mail**	
602 279 2337				6022309025		NA	
Schedule II Drugs	✓	**Schedule III Drugs**	✓	**Prescription-Only Drugs**	✓	**Nubain**	✓
Schedule IV Drugs	✓	**Schedule V Drugs**	✓	**Prescription Devices**	✓		

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

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

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

Physician's Signature: [signature] **Date:** 4/12/05

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

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ARIZONA MEDICAL BOARD

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ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Gabrielle J. Goodrick, MD

LICENSE #: 22811 SPECIALTY: Family Medicine

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

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

PLEASE NOTE

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

PRIMARY PRACTICE LOCATION: DEA # FOR THIS LOCATION: [redacted] 9/30/07

Street Address				City/State/Zip Code			
4141 N 32ND St #105				Phoenix AZ 85018-4775			
Phone Number				**Fax Number**		**E Mail**	
602 279 2337				6022309025			
Schedule II Drugs	✓	**Schedule III Drugs**	✓	**Prescription-Only Drugs**	✓	**Nubain**	✓
Schedule IV Drugs	✓	**Schedule V Drugs**	✓	**Prescription Devices**	✓		

ADDITIONAL PRACTICE LOCATION: N/A **DEA # FOR THIS LOCATION:**

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

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

Physician's Signature: [signature] Date: 5-15-06

Initial registration fee: $200.00 *per physician* **Renewal registration fee: $150.00 *per physician***

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ARIZONA MEDICAL BOARD

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BUSINESS OPERATIONS

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Gabrielle J. Goodrick, MD

LICENSE #: 22811 SPECIALTY: Family Medicine

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

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

PLEASE NOTE

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

PRIMARY PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** 9/30/07

Street Address				City/State/Zip Code			
4141 N 32ND St #105				Phoenix AZ 85018			
Phone Number				**Fax Number**		**E Mail**	
602 279 2337				602 230 9025		NA	
Schedule II Drugs	✓	**Schedule III Drugs**	✓	**Prescription-Only Drugs**	✓	**Nubain**	✓
Schedule IV Drugs	✓	**Schedule V Drugs**	✓	**Prescription Devices**	✓		

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

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

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

Physician's Signature: [signature] Date: 5-11-07

Initial registration fee: $200.00 *per physician* **Renewal registration fee: $150.00 *per physician***

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

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

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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

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Gabrielle Goodrick, MD

LICENSE #: 22811

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	X	Schedule III Drugs	X	Prescription-Only Drugs	X	Nubain	X
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices	X		

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

PRIMARY PRACTICE LOCATION:

4141 N 32ND St #105 Phoenix AZ 85018 602 279-2337

Street Address | City, State, Zip Code | Phone #

[redacted] | 8/2/07 | 9/30/10

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

ADDITIONAL PRACTICE LOCATION:

NA

Street Address | City, State, Zip Code | Phone #

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

Physician's Signature: [signature] Date: 9-9-08

GS 9.11.08

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

ARIZONA MEDICAL BOARD

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Home Page: http://www.azmd.gov

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AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Gabrielle Julie Goodrick, MD

MD LICENSE #: 22811 SPECIALTY: Family Medicine

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

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

[redacted]

4141 N 32ND ST #105
PHOENIX, AZ 85018

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

[X] Dispensing location information correct [X] Copy of DEA attached [ ] Remove this location

Physician's Signature: [signature] Date: 5-28-09

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2701 . Fax (480) 551-2700
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55291

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AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Gabrielle Julie Goodrick, MD

MD LICENSE #: 22811

SPECIALTY: Family Medicine

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

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

[redacted]

✓ 4141 N 32ND ST #105
PHOENIX, AZ 85018

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: 5-10-10

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	09-30-2010	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	08-03-2007

GOODRICK, GABRIELLE JULIE MD
4141 N 32ND ST
SUITE 105
PHOENIX, AZ 85018 4775

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

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

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

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

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	09-30-2010	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	08-03-2007

GOODRICK, GABRIELLE JULIE MD
4141 N 32ND ST
SUITE 105
PHOENIX, AZ 85018 4775

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 (08/04)

ARIZONA MEDICAL BOARD

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AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Gabrielle Julie Goodrick, MD

MD LICENSE #: SPECIALTY: Family Medicine 25073

☒ **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.

4141 N 32ND ST #105
PHOENIX, AZ 85018

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: 5-9-11

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	09-30-2013	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	08-10-2010

GOODRICK, GABRIELLE JULIE MD
4141 N 32ND ST
SUITE 106
PHOENIX, AZ 85018 4775

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

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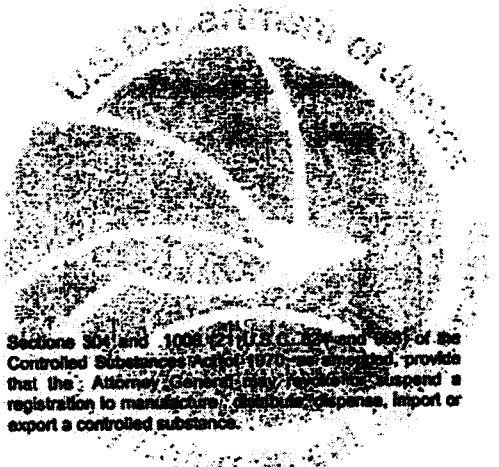
CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	09-30-2013	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	08-10-2010

GOODRICK, GABRIELLE JULIE MD
4141 N 32ND ST
SUITE 106
PHOENIX, AZ 85018 4775



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.

Form DEA-223 (08/04)

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

ARIZONA MEDICAL BOARD
2003 BIENNIAL MD LICENSE RENEWAL APPLICATION

3303

AZ MD Lic#: 22811 Gabrielle J. Goodrick, MD

Renewal Fee: $450 $800 (If postmarked after 06/23/2003)

CURRENT INFORMATION
Please verify and make corrections if necessary

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
PUBLIC ADDRESS/PHONE NUMBER
5040 N 15th Ave Ste 303
Phoenix AZ 85015-3331

Phone #: (602) 279-2337 Fax #: (602) 230-9025
E-Mail:

MAILING ADDRESS
5040 N 15th Ave Ste 303
Phoenix AZ 85015-3331

HOME ADDRESS
[redacted]

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

CHANGES

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS

Phone #: Fax #:
E-Mail:

MAILING ADDRESS

RECEIVED
MAY 5 2003
By

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

Make corrections if necessary

	Certified?	Practicing?
FP	Y	Y

	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?
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
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 written explanation. If malpractice cases are reported, [illegible] please include: the case number, venue, plaintiff name, and attorney names/addresses/phone numbers [illegible].

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)

3/26/03
Date

[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

Pd cc

AZ MD Lic#: 22811 Gabrielle J. Goodrick, MD **Renewal Fee: $500** **$850** (if postmarked after 06/23/2005)

CURRENT INFORMATION Please review and make corrections if necessary	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 5040 N 15th Ave Ste 303 Phoenix AZ 85015-3331	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**
Phone #: (602) 279-2337 **Fax #:** (602) 230-9026 **E-Mail:**	**Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS 5040 N 15th Ave Ste 303 Phoenix AZ 85015-3331	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** **E-Mail:**	**Phone #:** **Fax #:** **E-Mail:** **Cell Phone #:** (Optional)

RECEIVED MAR 31 2005 By

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

	Certified?	Practicing?
FP	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 safely practice medicine? **(see instructions)** [redacted]
7. Do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication?
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?
9. Have you been denied a license in another state? If yes, ☐ Yes ☒ No
   State_____ Date of Denial_____ Reason for Denial_____
10. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? ☐ Yes ☒ No
    If yes, please attach an explanation and applicable court docket. See instructions on back.
11. Since your last renewal, has a malpractice lawsuit resulted in a settlement or judgment against you? ☐ Yes ☒ No

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

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

Gabrielle Goodrick

Signature of Licensee (Signature stamp will not be accepted)

3/26/05

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#: 22811 Gabrielle J. Goodrick, MD — **Renewal Fee: $500 $850 (if postmarked after 06/23/2007)**

CURRENT INFORMATION Please review and make corrections as necessary ™	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER 4141 N. 32nd St., Suite 105 Phoenix AZ 85018	OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
Phone #: (602) 279-2337 Fax #: (602) 230-9025 E-Mail:	Phone #: Fax #: E-Mail:
MAILING ADDRESS 4141 N. 32nd St., Suite 105 Phoenix AZ 85018	MAILING ADDRESS
HOME ADDRESS [redacted]	HOME ADDRESS
Phone #: [redacted] Fax #: E-Mail: Mobile #:	Phone #: Fax #: E-Mail: Mobile #: (Optional)

RECEIVED
MAR 27 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?
FP	Y	Y

Make corrections if necessary INITIALS REQUIRED

	Certified?	Practicing?	Expiration Date	Initials Required

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. §32-3210.

Gabrielle J. Goodrick MD — 3/27/07

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

22811 Gabrielle J. Goodrick, MD

SEE REVERSE SIDE

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.

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 22811 Renewal Fee: $500 $850 (if postmarked 30 days after due date)

Name: Gabrielle Julie Goodrick, MD

OFFICE ADDRESS/ PRINCIPAL PLACE OF BUSINESS
PUBLIC ADDRESS & PHONE NUMBER
4141 N 32ND St #105
Phoenix, AZ. 85018
602 279 2337

Phone #: Fax #: 602.230.9025

E-Mail: [redacted]

MAILING ADDRESS
Same

MAR 26 2009

HOME ADDRESS
[redacted]

Phone #: [redacted]
Mobile #

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

Field of Practice Code (see attached form for code)	ABMS Certified? (Y/N)	Practicing? (Y/N)	Expiration Date (or indicate lifetime certificated)
1-M	Y	Y	12/31/2009

REQUEST FOR CHANGE IN LICENSE STATUS:

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

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

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

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

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

Gabrielle J. Goodrick 3/26/09

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

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

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

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

Name: Gabrielle J. Goodrick License Number: 22811

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

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

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

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

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

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

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

Please note: All documents requested above must be sent directly from the primary source to the Arizona Medical Board's Physician Health Program Department from the primary source and will not be accepted if submitted by the applicant. FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.

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

Name: Gabrielle J. Goodrick License Number: 22811

Signature: [signature]

The Secretary of State of the United States of America
hereby requests all whom it may concern to permit the citizen/national
of the United States named herein to pass without delay or hindrance
and in case of need to give all lawful aid and protection.

Le Secrétaire d'Etat des Etats-Unis d'Amérique
prie par les présentes toutes autorités compétentes de laisser passer le citoyen
ou ressortissant des Etats-Unis titulaire du présent passeport, sans délai ni
difficulté et, en cas de besoin, de lui accorder toute aide et protection légitimes.

El Secretario de Estado de los Estados Unidos de América por el presente solicita a las
autoridades competentes permitir el paso del ciudadano o nacional de los Estados Unidos
aquí nombrado, sin demora ni dificultades, y en caso de necesidad, prestarle toda la
ayuda y protección lícitas.

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE/FIRMA DEL TITULAR

NOT VALID UNTIL SIGNED

PASSPORT / PASSEPORT / PASAPORTE

UNITED STATES OF AMERICA

Type / Type / Tipo: P
Code / Code / Código: USA
Passport No. / No. de Passeport / No. de Pasaporte: [redacted]

Surname / Nom / Apellidos:
GOODRICK

Given names / Prénoms / Nombres:
GABRIELLE JULIE

Nationality / Nationalité / Nacionalidad:
UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento:
[redacted]

Sex / Sexe / Sexo: F

Place of birth / Lieu de naissance / Lugar de nacimiento:
[redacted]

Date of issue / Date de délivrance / Fecha de expedición:
28 APR 2007

Authority / Autorité / Autoridad:
United States Department of State

Date of expiration / Date d'expiration / Fecha de vencimiento:
27 APR 2012

Endorsements / Mentions supplémentaires / Observaciones:
SEE PAGE 24

P<USAGOODRICK<<GABRIELLE<JULIE<<<<<<<<<<<<<<
[redacted]<<<<<<<<<<<<<<06

Individual - Gabrielle Julie Goodrick

2011 Renewal

License#	License Type
22811	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 - Gabrielle Julie Goodrick

2011 Renewal

License#	License Type
22811	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]

****

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

December 6, 2006

Gabrielle J. Goodrick, MD
4141 N. 32nd St., Suite 105
Phoenix AZ 85018

Re: G.H. v Gabrielle Julie Goodrick
MD-06-0460A

Dear Dr. Gabrielle J. Goodrick:

The Arizona Medical Board has thoroughly investigated this case and found no violation of the Medical Practice Act. Therefore, this case has been dismissed.

The complainant may appeal this dismissal within 35 days of the date of this letter. If this should occur, you will be notified by mail.

Sincerely,

Timothy C. Miller, J.D.
Executive Director

TCM/cg

Enclosure

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of GABRIELLE J. GOODRICK, M.D. Holder of License No. 22811 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-10-1229A INTERIM ORDER FOR PRACTICE LIMITATION AND CONSENT TO THE SAME (NON-DISCIPLINARY)

INTERIM CONSENT AGREEMENT

Gabrielle J. Goodrick, M.D. ("Physician") elects to permanently waive any right to a hearing and appeal with respect to this Interim Order for Practice Limitation; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Physician is the holder of License No. 22811 for the practice of allopathic medicine in the State of Arizona.

3. Physician has recognized that she has a medical condition that may limit her ability to safely engage in the practice of medicine.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Physician.

2. The Executive Director has authority to enter into this consent agreement to limit the physician's practice based upon evidence that he is unable to safely engage in the practice of medicine pursuant to A.R.S. § 32-1405(C)(25) and § 32-1451(F); A.A.C. R4-16-504.

3. The Executive Director has determined that a consent agreement is needed to mitigate imminent danger to the public health and safety. Investigative staff and the Board's medical consultant have reviewed the case and concur that a consent agreement is appropriate.

4. There has been no finding of unprofessional conduct against Physician.

ORDER

IT IS HEREBY ORDERED THAT:

1. Physician's practice is limited in that she shall not practice medicine in the State of Arizona and is prohibited from prescribing any form of treatment including prescription medications until Physician applies to the Board and receives permission to do so. The Board may require any combination of staff approved assessments, evaluations, treatments, examinations or interviews it finds necessary to assist in determining whether Physician is able to safely resume such practice.

2. Physician may be assessed the costs of the contractor's fees for monitoring.

3. The Board retains jurisdiction and may initiate a separate disciplinary action based on the facts and circumstances that form the basis for this practice limitation or any violation of this Consent Agreement.

DATED this 1st day of OCTOBER, 2010.

ARIZONA MEDICAL BOARD

[SEAL]

By _____
Lisa S. Wynn, Executive Director

CONSENT TO ENTRY OF ORDER

1. Physician has read and understands this Interim Order for Practice Limitation and Consent to the Same and the stipulated Findings of Fact, Conclusions of Law and Order ("Interim Order"). Physician acknowledges she has the right to consult with legal counsel regarding this matter.

2. Physician acknowledges and agrees that this Interim Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Interim Order, Physician voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Interim Order in its entirety as issued, and waives any other cause of action related thereto or arising from said Interim Order.

4. The Interim Order is not effective until approved and signed by the Executive Director.

5. All admissions made by Physician are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Physician. Therefore, said admissions by Physician are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Physician may not revoke the consent to the entry of the Interim Order. Physician may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Interim Order is a public record that will be publicly disseminated as a formal ***non-disciplinary*** action of the Board.

8. If any part of the Interim Order is later declared void or otherwise unenforceable, the remainder of the Interim Order in its entirety shall remain in force and effect.

9. Any violation of this Interim Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

Gabrielle J. Goodrick, M.D. DATED: 10-1-10

EXECUTED COPY of the foregoing e-mailed
this 1 day of Oct, 2010 to:

Gabrielle J. Goodrick, M.D.
ADDRESS OF RECORD

ORIGINAL of the foregoing filed
this 5 day of Oct, 2010 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Arizona Medical Board Staff

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

February 10, 2011

Calvin Raup
Raup & Hergenroether, PLLC
One Renaissance Square
Two N. Central Avenue, Suite 1100
Phoenix, AZ 85004-0001

RE: Gabrielle J. Goodrick, M.D.
Case # MD-10-1378A

Dear Mr. Raup:

The Arizona Medical Board (Board) considered the above-referenced matter during the course of their February 9, 2011, public meeting.

Following a complete and thorough review of all pertinent and available information, the Board concluded that your client was not in violation of the Medical Practice Act of the State of Arizona and, accordingly, dismissed the matter.

On behalf of the Board, thank you for allowing the Board to review this matter.

Sincerely,

Amanda Schwabe

Amanda Schwabe
Board Coordinator
E-Mail: boardcoordinator@azmd.gov
Phone: (480) 551-2712
Fax: (480) 551-2705

Within six months, complete the PACE prescribing course and the PACE medical recordkeeping course. The course hours shall be in addition to the CME hours required for the biennial renewal of licensure.
SECONDED: Dr. Khera

Dr. Lee spoke against the motion and stated that he found that there was sufficient evidence to support a disciplinary action on the issue of egregiously poor medical records.

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Dr. Jenkins, Dr. Khera, Dr. Petelin, Ms. Proulx, and Dr. Thrift. The following Board members voted against the motion: Ms. Ibanez, Dr. Lee and Dr. Schneider. The following Board member was absent: Dr. Krishna.
VOTE: 6-yay, 3-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Ms. Boucek informed the Board that the Advisory Letter and CME Order will be drafted as separate documents. She stated that if Dr. Onisile is noncompliant with the CME Order, the Board can bring a separate action against him for violation of a Board Order. Board members confirmed that they believed they were voting on both the Advisory Letter and CME Order in one motion.

2	MD-10-1229A	GABRIELLE J. GOODRICK, M.D.	22811	Draft Findings of Fact, Conclusions of Law and Order for an Order of Probation to participate in PHP for a period of five years. The Probation shall include psychiatric monitoring. The Probation shall also include a Practice Restriction prohibiting the physician from having intravenous drugs in her office practice. After two months, Dr. Goodrick may petition the PHP monitor requesting modification of the Practice Restriction to allow the use of Versed in her office practice. Dr. Goodrick may not request termination of the Practice Restriction until after three years of PHP participation. This Order shall supersede any and all previous Orders. Dr. Goodrick's PHP participation is retroactive to December 21, 2010.
	MD-10-1378A			Dismiss.

Dr. Goodrick was present with legal counsel, Mr. Calvin Raup. Dr. Lee stated that he knows Mr. Raup, but it would not affect his ability to adjudicate the case. Ms. Muller summarized that in case MD-10-1229A, Dr. Goodrick underwent a chemical dependency evaluation and entered into an Interim Practice Restriction with the Board. Ms. Muller stated that Dr. Goodrick completed treatment for substance abuse on December 9, 2010 and entered into the Board's Physician Health Program under an Interim Order. Marlene Young, Investigator, informed the Board that in the matter of MD-10-1378A, the Board received notification from the Department of Health Services indicating that on October 11-12, 2010, Dr. Goodrick was practicing medicine in violation of her October 1, 2010 Interim Order for Practice Limitation. Dr. Goodrick stated that the allegations from the Department of Health Services stemmed from a clerical error that occurred in her practice. Dr. Goodrick stated that she has not seen patients and that she has not rendered any care while under the Interim Practice Restriction. Dr. Petelin expressed concern that Dr. Goodrick may be allowing her registered nurses to practice medicine in her office, based upon her definition of the practice of medicine submitted in support of her claim that she has not violated the Interim Practice Limitation. Dr. Goodrick stated that it is the standard of care in the community that a registered nurse may work under the direction of a physician, and can administer medication under a physician's standing orders. In closing, Mr. Raup stated that case law provides that the practice of medicine does not include administrative duties performed in a physician's practice. He stated that with regard to the five patients in question, Dr. Goodrick looked at the patients' charts after the patient had already received medical services and left the office. He stated that he finds it difficult to believe that an individual who accidentally violates the statute can still be disciplined by the Board. Dr. Lee found that in MD-10-1229A, Dr. Goodrick has engaged in unprofessional conduct.

MOTION: Dr. Lee moved for a finding of unprofessional conduct in violation of A.R.S. §32-1401(27)(f) - Habitual intemperance in the use of alcohol or habitual substance abuse; and A.R.S. §32-1401(27)(g) - Using controlled substances except if prescribed by another physician for use during a prescribed course of treatment.
Seconded: Ms. Proulx
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Lee stated that he finds this matter rises to the level of discipline. He questioned whether the Board was required to issue a Letter of Reprimand when placing the physician on Probation for PHP participation. Ms. Boucek informed the Board that the probationary Order itself is considered discipline, and that by adding a Letter of Reprimand, the physician is being reprimanded for the unprofessional conduct.

MOTION: Dr. Lee moved for a draft Findings of Fact, Conclusions of Law and Order for an Order of Probation to participate in PHP for a period of five years. The Probation shall include psychiatric monitoring. The Probation shall also include a Practice Restriction prohibiting the physician from having intravenous drugs in her office practice. After two months, Dr. Goodrick may petition the PHP monitor requesting modification of the Practice Restriction to allow the use of Versed in her office practice. Dr. Goodrick may not request termination of the Practice Restriction until after three years of PHP participation. This Order shall supersede any and all previous Orders. Dr. Goodrick's PHP participation is retroactive to December 21, 2010.
SECONDED: Dr. Jenkins

Ms. Boucek recommended that the Board include in its motion that the Order shall supersede all prior orders of the Board. Drs. Jenkins and Lee agreed to modify their motion to include the language as recommended by Ms. Boucek.

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Ms. Ibanez, Dr. Jenkins, Dr. Khera, Dr. Lee, Dr. Petelin, Ms. Proulx, Dr. Schneider, and Dr. Thrift. The following Board member was absent: Dr. Krishna.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

In the matter of MD-10-1378A, Dr. Lee stated that he found that Dr. Goodrick has engaged in unprofessional conduct by violating the Interim Practice Limitation.

MOTION: Dr. Lee moved for a finding of unprofessional conduct in violation of A.R.S. §32-1401(27)(r) - Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter.
SECONDED: Dr. Petelin

Dr. Schneider noted that Dr. Goodrick employed a locum tenens physician for coverage while her license was restricted, who made clinical decisions in her office. Dr. Schneider spoke against the motion and stated that this matter does not rise to the level of unprofessional conduct. Dr. Lee stated that he takes a Board Order very seriously. He stated that to devalue the signature on a clinical chart does a disservice to physician as clinical providers. Dr. Thrift spoke against the motion and stated that it is clear that Dr. Goodrick attempted to establish procedures in her practice in order to comply with the Board Order.

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Ibanez, Dr. Lee, and Dr. Petelin. The following Board members voted against the motion: Ms. Griffen, Dr. Jenkins, Dr. Khera, Ms. Proulx, Dr. Schneider, and Dr. Thrift. The following Board member was absent: Dr. Krishna.
VOTE: 3-yay, 6-nay, 0-abstain, 0-recuse, 1-absent.
MOTION FAILED.

MOTION: Dr. Lee moved to issue an Advisory Letter for violation of a Board Order by making signatures on a chart that implied that the patient was being cared for by that physician.
SECONDED: Dr. Petelin

Ms. Boucek advised the Board not to include violation of a Board Order in its motion, as the Board expressly voted against a finding of unprofessional conduct. She recommended that the Board issue the Advisory Letter for Dr. Goodrick's signing of patients' charts in a manner that may have given the impression that she was authorized to practice medicine while under a Practice Restriction. Dr. Lee questioned whether the Advisory Letter motion could mention medical records as the physician had not been noticed of a medical records violation. Ms. Boucek advised the Board to enter into Executive Session to receive legal advice.

MOTION: Dr. Lee moved to enter into Executive Session to receive legal advice.
SECONDED: Dr. Jenkins
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board entered into Executive Session at 1:15 p.m.
The Board returned to Open Session at 1:20 p.m.
No deliberations or discussions were made during Executive Session.

Drs. Jenkins and Lee withdrew their previous motion.

MOTION: Dr. Schneider moved to dismiss case MD-10-1378A.
SECONDED: Dr. Khera
ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Ms. Ibanez, Dr. Jenkins, Dr. Khera, Dr. Schneider, and Dr. Thrift. The following Board members voted against the motion: Dr. Lee, Dr. Petelin, and Ms. Proulx. The following Board member was absent: Dr. Krishna.
VOTE: 6-yay, 3-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Mr. Raup questioned the Board as to when Dr. Goodrick may return to practice and begin scheduling patients. Ms. Boucek stated that the Board Order arising from the Formal Interview would supersede the Interim Practice Limitation.

The Board returned to this case later in the day. Ms. Boucek stated that it came to her attention that the treatment center and Board contractors deemed Dr. Goodrick safe to return to practice while being monitored by PHP but recommended that Dr. Goodrick not be allowed to have intravenous drugs in her office. Ms. Boucek recommended that the Board move to make the Order immediately effective upon the Executive Director's execution of the Order.

MOTION: Ms. Griffen moved for the Board's Order to become immediately effective upon the Executive Director's execution of the Order.
SECONDED: Dr. Petelin
ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Ms. Ibanez, Dr. Jenkins, Dr. Khera, Dr. Lee, Dr. Petelin, Ms. Proulx, Dr. Schneider, and Dr. Thrift. The following Board member was absent: Dr. Krishna.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

3.	MD-10-0682A	VICKY E. SHERMAN, M.D.	21558	Issue an Advisory Letter for failure to complete a tubal ligation and inform the patient of the failure to complete the procedure. This is a technical error that does not rise to the level of discipline.

Dr. Sherman was present with legal counsel, Ms. Sandra Rogers. Dr. Schneider stated that she knows Dr. Sherman, but it would not affect her ability to adjudicate the case. Dr. Haas summarized that Dr. Sherman failed to complete a tubal ligation and inform the patient of the failure to complete the procedure. Dr. Sherman stated that she recognizes she made a mistake in this case, and that she takes full responsibility. Dr. Sherman explained that the patient's consent forms for the tubal ligation and repeat cesarean section were separate forms signed by the patient. The patient later became pregnant while being under the impression that she had undergone the tubal ligation. Dr. Sherman told the Board that the patient remained under her care throughout her pregnancy and is happy with the outcome. Dr. Sherman reported that the hospital has combined the two procedures on one form in an effort to prevent a future similar occurrence. Additionally, Dr. Sherman stated that the hospital now requires a physician's signature on the consent form before the patient can be taken to the operating room. Dr. Petelin expressed concern with the failure to inform the patient that the procedure had not been performed, and noted that there were significant risks involved for the mother and baby. Dr. Petelin found that there were two missed opportunities to inform the patient. In closing, Ms. Rogers stated that Dr. Sherman has been the most honest physician that she has represented. She stated that Der. Sherman has not tried to avoid responsibility for her mistake. Ms. Rogers pointed out that Dr. Sherman has no prior Board history, and stated that this matter does not warrant discipline. Dr. Schneider found that Dr. Sherman was very contrite in her testimony. Dr. Schneider found that Dr. Sherman did engage in unprofessional conduct by deviating from the standard of care by failing to perform the procedure.

MOTION: Dr. Schneider moved for a finding of unprofessional conduct in violation of A.R.S. §32-1401(27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ms. Griffen
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Schneider stated that she found this matter does not rise to the level of discipline and recommended issuing the physician an Advisory Letter for a technical violation. Dr. Schneider stated that Dr. Sherman has demonstrated remediation in her processes.

MOTION: Dr. Schneider moved to issue an Advisory Letter for failure to complete a tubal ligation and inform the patient of the failure to complete the procedure. This is a technical error that does not rise to the level of discipline.
SECONDED: Ms. Ibanez

Dr. Petelin spoke in favor of the motion. He pointed out that at the Board's previous meeting, discipline was issued to a physician who was found to have overlooked a chest x-ray report and a malignancy was missed. He found that the matter was similar to the current case, and expressed concern that the Board is not being consistent in issuing discipline versus non-disciplinary actions. Dr. Jenkins disagreed, and stated that she recalled the prior case involving another physician regarded a chest x-ray ordered by the physician who had control over the follow up that occurred with the patient. She stated that this current case involving Dr. Sherman is different in that the processes were not followed at the hospital, which was out of Dr. Sherman's control. Dr. Petelin commented that had the outcome been adverse to either the mother or baby, the Board may look at the case differently. Dr. Schneider disagreed and noted that the end result was a child, and that the prior matter resulted in the patient's death.

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Ms. Ibanez, Dr. Jenkins, Dr. Khera, Dr. Lee, Dr. Petelin, Ms. Proulx, Dr. Schneider, and Dr. Thrift. The following Board member was absent: Dr. Krishna.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The meeting adjourned at 4:28 p.m.

Lisa S. Wynn, Executive Director

14.	MD-11-0067A	DEBJOTI SENSHARMA, M.D.	25654	Uphold the Dismissal.
15.	MD-11-0049A	JAMES W. BAIRD, M.D.	28720	Uphold the Dismissal.
16.	MD-10-1284B	EARL E. ROTH, M.D.	14021	Uphold the Dismissal.

OTHER BUSINESS
MOTION: Dr. Schneider moved to accept the Proposed Consent Agreement in item numbers 1-3.
SECONDED: Dr. Krishna
ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Ibáñez, Dr. Jenkins, Dr. Khera, Dr. Krishna, Dr. Lee, Dr. Petelin, Ms. Proulx, Dr. Schneider, and Dr. Thrift. The following Board member was absent: Ms. Griffen.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

1.	MD-10-1347A	DAVID L. CHILD, M.D.	6275	Accept the proposed Consent Agreement for a Decree of Censure and One Year Probation. Within six months, complete a PACE evaluation.
2.	MD-10-0514A	NAGLAA Z. ABDEL-AL, M.D.	34898	Accept the proposed Consent Agreement for a Decree of Censure and Practice Restriction. Dr. Abdel-Al shall not practice medicine and is prohibited from prescribing any form of treatment, including prescription medications, in Arizona. In addition, Dr. Abdel-Al shall not seek to renew her Arizona medical license and shall not reapply for an Arizona medical license for a period of five years.
3.	MD-10-1261A	CLIFFORD J. GOODMAN, M.D.	8263	Accept the proposed Consent Agreement for a Letter of Reprimand.
4.	MD-10-0947A	NAVNEET N. SHARDA, M.D.	27157	Approve the draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand, and instructed Board legal counsel to add additional information to reflect the outcome of the superior court case.

Dr. Lee informed the Board that additional information had been received from Dr. Sharda regarding the judicial review of the Nevada Board action. Dr. Lee stated that the Nevada Board Order remains effective. Ms. Boucek advised the Board to include in its motion for approval of the draft that the Board's legal counsel is instructed to add additional information to reflect the outcome of the superior court case.

MOTION: Dr. Schneider moved to approve the draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand, and instructed Board legal counsel to add additional information to reflect the outcome of the superior court case.
SECONDED: Dr. Petelin
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

5.	MD-10-0812A	GALEN B. JOHNSON, M.D.	19218	Issue an Order to undergo a psychosexual evaluation within sixty days. If Dr. Johnson fails to undergo the evaluation within sixty days, the case shall be referred to the Office of Administrative Hearings for a Formal Hearing with the recommendation for Revocation.

Dr. Johnson spoke during the call to the public. Ms. Boucek clarified that the criminal case against Dr. Johnson is currently pending. She stated that licensee's with pending criminal cases are often advised by their legal counsel not to undergo the assessment because the prosecutor in the criminal case may potentially subpoena the Board for the evaluation. Dr. Lee stated that despite the pending criminal case and the potential for criminal charges against Dr. Johnson, the issue remains that he has failed to undergo a psychosexual evaluation as ordered by the Board's Executive Director. Pat McSorley, Investigations Manager, informed the Board that the county attorney's office has reported that no charges have been filed, but that the case is still under review. Dr. Krishna noted that Board staff has recommended that if Dr. Johnson does not complete an evaluation within sixty days of the effective date of the Order, the case shall be referred for Formal Hearing with the recommendation to revoke the physician's license.

MOTION: Dr. Schneider moved to issue an Order to undergo a psychosexual evaluation within sixty days. If Dr. Johnson fails to undergo the evaluation within sixty days, the case shall be referred to the Office of Administrative Hearings for a Formal Hearing with the recommendation for Revocation.
SECONDED: Dr. Krishna
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

6.	MD-10-1229A	GABRIELLE J. GOODRICK, MD	22811	Grant the request for modification of the Board Order by allowing Dr. Goodrick to use IV Versed and non-opioid IV medications in her practice. The Practice Restriction on all other opioid medications

				shall remain in effect.

Kathleen Muller, Physician Health Program (PHP), summarized that in February 2011, Dr. Goodrick was issued a Board Order for Probation to participate in PHP for five years which included psychiatric monitoring and a practice restriction that prohibits Dr. Goodrick from having intravenous (IV) drugs in her office practice. The Order provided that Dr. Goodrick may petition the Board after two months to request the use of IV Versed in her office practice. Ms. Muller stated the PHP Contractor has reported that Dr. Goodrick is compliant with the program requirements and recommended that the Practice Restriction on Versed be removed, and that she be allowed to use non-opioid IV medications in her office, but that the Practice Restriction on all other opioid medications shall remain in effect.

MOTION: Dr. Krishna moved to grant the request for modification of the Board Order by allowing Dr. Goodrick to use IV Versed and non-opioid IV medications in her practice. The Practice Restriction on all other opioid medications shall remain in effect.
SECONDED: Dr. Thrift

Dr. Petelin observed that Dr. Goodrick has requested that the Board clarify which specific non-opioid medications she is permitted to use while under the Practice Restriction. Dr. Lee stated that all non-opioid medications can be used, and instructed Board staff address the physician's request for clarification. Dr. Lee further stated that the Board Order is fairly clear in that Dr. Goodrick is restricted from using any IV opioid medications in her practice.

VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

7.	MD-98-0050	ROGER M. NOCERA, M.D.	14570	Grant the request for termination of the January 19, 2000 Board Order.

Ms. Muller summarized that in January 2000, Dr. Nocera entered into a Consent Agreement limiting his work hours to 30 hours per week and required that he work in an office or clinic setting. She stated that the Agreement prohibits Dr. Nocera from performing angiography or any other procedures that may aggravate his medical condition. Ms. Muller informed the Board that Dr. Nocera's treating physician submitted correspondence to Board staff indicating that Dr. Nocera is fully recovered from his medical condition and is capable of practicing medicine safely without restriction.

MOTION: Dr. Krishna moved to grant the request for termination of the January 19, 2000 Board Order.
SECONDED: Dr. Jenkins

Dr. Petelin observed that Dr. Nocera has been restricted from performing angiography for the past eleven years and is requesting that the Practice Restriction be lifted. Dr. Petelin expressed concern regarding allowing Dr. Nocera to perform angiography after an eleven year lapse and questioned whether the Board should limit his practice. Dr. Krishna stated that hospital staff typically determines whether a physician is competent to perform angiography procedures. Dr. Khera spoke in favor of the motion and pointed out that most hospitals require a physician to have experience in performing angiography procedures within the past three years, and that Dr. Nocera would not meet the criteria.

VOTE: 8-yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

8.	MD-11-0035A	JULES F. LEVEY, M.D.	N/A	Deny the license.

Dr. Levey spoke during the call to the public with Steven Lupiloff. Dr. Krishna observed that Dr. Levey currently does not qualify for an Arizona license due to unresolved issues in other states.

MOTION: Dr. Krishna moved to deny the license.
SECONDED: Ms. Proulx

Ms. Boucek clarified that the license application has been considered, and that the Board shall determine whether it is appropriate to grant or deny the license.

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Ibáñez, Dr. Jenkins, Dr. Khera, Dr. Krishna, Dr. Lee, Dr. Petelin, Ms. Proulx, Dr. Schneider, and Dr. Thrift. The following Board member was absent: Ms. Griffen.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

9.	MD-09-1169A	NAVNEET ADYA, M.D.	31619	Accept the proposed Consent Agreement for Surrender of License.

MOTION: Dr. Schneider moved to accept the proposed Consent Agreement for Surrender of License.