

#### Arizona State Board of Medical Examiners

P.O. Box 6200, Scottsdale, Arizona 85261 -6200

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

Telephone (480) 551-2700 • Fax (480) 5512704 • In State Toll Free (877) 255-2212

# APPLICATION for LICENSE to PRACTICE ALLOPATHIC MEDICINE in the STATE of ARIZONA and Initial Registration Form

Attach an approximate 2 ½" x 3" photograph of passport quality of your head and shoulders only.	FOR BOARI DO NOT USE TH		ACE
Photo must have been taken within the last 50 days and be signed in ink across the lower portion of the front side.	Date Application Sent:	□U	NDORSEMENT SMLE PEX
Proof photos, negatives, Polaroid type photos are not acceptable.	Date Application Received: 1/31/02	L	3818

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

#### INFORMATION

All candidates shall provide satisfactory evidence that he/she:

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

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 Applications not fully complete within one year from date of notification of deficiency in application are considered withdrawn.

# APPLICATION INSTRUCTIONS (Read Carefully)

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

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

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

#### **APPLICATION and Initial Registration**

	(To be completed, signed by applicant and notarized. All questions MUST be	answered	completely.)		
1.	Present Legal Name DURTON MEMIE CLIPTO (Middle)	,,	(Maiden)		
2	Office Address: 4212 No 12th St. Phosen & A	7 8	°5028	(602) 263	1550
	(No. (Zip/Post City and State of Birth.	Code)	(Area code/		
4.	In what states or provinces have you applied for or been granted license or registration? If mor If license not issued, so state.	e than two	o, attach separ	rate listing.	
	(a) Michigan 1963 GRANTEL (State Board) (Date of Application) (Result	)	25 (Certificate	923 No.)	
	(Date Issued) (Specify if by Written Exa mination or on Credentials	<u>)</u>		<u>,                                      </u>	
	(b)		(Cartificate	N <sub>2</sub>	
	(State Board) (Date of Application) (Result		(Certificate	No.)	
	(Date Issued) (Specify if by Written Examination or on Credentials		r questions e	on line at right.	
5.	Have you ever had an application or medical license denied or rejected by another state/provi nce licensing board?	in c	-	m nne at right.	
6.	Has any disciplinary or rehabilitative action ever been taken against you by any state licensing board, including other health professions? Examples of actions include but are not limited to reprimand, censure, probation, restriction, limitation, suspension, stipulation, written consent agreement or revocation.		T 00	altacher	L D 4.
7.	Have any disciplinary actions, restrictions, limitations ever been taken against you while you were participating in any type of training program or by any health care provider?	NO NE2	Jee	auro-nec	y yever
8.	Have you ever been found to be in violation of any statute, rule or regulation of any domestic or foreign governmental agency?	N0			
9.	board or association?	ηo	-		
	Are you currently under investigation by any medical board or peer review body?	f			
11.	Have you ever had a medical license disciplined resulting in a: revocation, suspension, limitation, restriction, probation, voluntarily surrender, cancellation during an investigation or entered into a consent agreement or stipulation?	YES	JAM4	08 46	
12.	Have you ever had hospital privileges revoked, denied, suspended or restricted in any way?	no			
	Have you ever been named as a defendant in any malpractice matter currently pending or which resulted in a settlement or judgement against you?	no			
14.	Have you ever been convicted of insurance fraud or received sanctions, including restriction, suspension or removal from practice, imposed by any agency of the federal government?	no			
15.	Have you ever had your ability to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered or revoked by a federal or state agency?	no	•		
		İ			

	Are your currently in engaged in the illegal use of any controlled substance, habit forming drug or prescription medication?
	Have you consumed intoxicating beverages resulting in your present ability to exercise the judgement and skills of a medical professional being impaired or limited?
	Have you been found guilty or entere d into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state?
add add	e: In the event the response to any of the questions numbered 5 through 18 is YES, the applicant will file with the lication a detailed report concerning the above matters, including any charge, date of such charge, the complete name and ress of all bodies of jurisdiction, the result of any hearings, and the disposition of such charge(s). Provide the name and ress of applicant's insurance carrier. IN ADDITION, the applicant must submit photocopy(ies) of any complaints, rings, settlements or judgements together with copies of patient's hospital and/or office records to this board.
19.	Do you have or have you had within the last five years any medical condition that in any way impairs or limits your ability to safely practice any field of medicine?
Al	pility to practice medicine is to be construed to include all of the following:
1.	The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2.	The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, suc h 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.
	on, emotion or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug -addiction and alcoholism.
20. With	on, emotion or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug -addiction and alcoholism.  hin the last five years, have you been diagnosed, treated or admitted to a hospital or facility for the treatment of bi -polar disorder, schizophrenia, paranoia, or any schotic disorder?
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20. With other psychology of the psychology of t	tinternship, Residency and Fellowship training (COMPLETED OR NOT), OR, Assistant Professorship (or higher) at approved school of medicine chronologically showing institution, address, type of program and dates. Attach separate listing if needed.  Internship, Residency and Fellowship training (COMPLETED OR NOT), OR, Assistant Professorship (or higher) at approved school of medicine chronologically showing institution, address, type of program and dates. Attach separate listing if needed.  In an author of Medical School:  In author of Medical School of Medical School Medical School of Medical
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The applicant Memie C. Burron, IR. M.D.	
(PRINT OR TYPE YOUR NAME AS YOU WISH IT TO APPEAR ON YOUR MEDICAL	LICENSE)
being first duly sworn upon his oath deposes and says: that he is the person herein named subscribing to this appropriate application, knows the full content thereof, and declares that all of the information contained herein are submitted herewith are true and correct; that he is the lawful holder of the degree of Doctor of Medicine as present the same was procured in the regular course of instruction and examination, and that it, together with all the procured without fraud or misrepresentation or any mistake of which the applicant is aware that the applications and professional associates (past, present and future), and all government agencies (local, state, fed Arizona Board of Medical Examiners or its successors any information, files or records, including medical records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the application; or any further or future investigation by that Board necessary to determine my medical competitive physical or mental ability to safely engage in the practice of medicine. I further authorize the Arizona Board successors to release to the organizations, individuals or groups listed above any information which is mat subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on deny the same or to hold a hearing to revoke the same, if issued.	d evidence or other credentials cribed by t his application, that he credentials submitted, were ant is the lawful holder thereof. yers (past, present and future), eral or foreign) to release to the ords, educational records, and t Board in connection with this tence, professional conduct or d of Medical Examiners or its erial to the applica tion or any
/ba Cl. V	Luch (h)
Signature of Applicant Will Seffor S	M.
STATE OF C	ZONA
(NOTARY SEAL)  COLLEGE CONTY  NOTARY PUBLIC - / COUNTY  MY COMMISSION EXPIRES  JUNE 10, 2005	2012
Subscribed and sworn to before me this 6 th day of February	20 02
0.11. 41.	
Notary Signature Collin Claim My Comission expires 670 C	<i></i>
·	
FOR OFFICIAL USE ONLY	
Application Processed by 3500	
Application Checked by	

Application Approved

30399

License Issued

License Number \_







Vho's Certified

Which Medical Specialist For You

Statistics









## American Board of Medical Specialties®









#### **Certifications**

Important Notice: This service is not completely accepted by the JCAHO and NCQA for commercial use to verify physician credentials because no dates are supplied.

For a definition of a specialty or subspecialty click here

Memie C. Burton Jr, MD

Locations:

Phoenix, AZ United States

Certified By: The American Board of Obstetrics & Gynecology

**General Certificates: Obstetrics & Gynecology** 

**Subspecialty Certificates:** 

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> American Board of Medical Specialties 1007 Church Street, Suite 404 | Evanston, IL 60201-5913 Phone Verification (866) ASK-ABMS Phone: (847) 491-9091 | Fax: (847) 328-3596 Copyright © 2000 American Board of Medical Specialties

#### 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, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

Name: Memie Clifton Burrows To. Momie Clifton	Tueston (h), M.D.
Address:  (Please Print by Tyne)  (Street)	
Date: 3/15/93	
(DO NOT DETACH)	
(This section with a current photograph of the applicant shall be forwarded to and completed by granting the medical degree. Please indicate to your medical school that this completed form must be redical Examiners.	an officer of the medical school eturned to the Arizona Board of
This is to certify that	
whose photograph is attached hereto, was granted the degree of DOCTOR OF MEDICINE	by
THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL  (Full Name of School or College of Medicine as it appears on the Applicant's Medical degree diploma)	JUNE 8, 19 63,
that the date of his/her matriculation in medical school was	59; and that he/she attended
that the date of his/her matriculation in medical school was SEPTEMBER 21, , 19 : 4 YEARS (Number) full courses of medical lectures comprising (Number) months each as verified by the school was september 21, 19 : 19 : 19 : 19 : 19 : 19 : 19 : 19	y the attached certified copy of
his/her transcripts.  SEE ATTACHED DEAN'S LETTER  1. Was applicant ever required to repeat any segment of training? If YES, which part(s)?	
2. Was applicant ever placed on probation, restricted or limited? If YES, please attach was	itten explanation.
3. Was there any reason not to continue applicant in the training program? If YES, pleas	e attach written explanation.
4. Was applicant ever known to use or misuse any chemical substance or substances which required treat If YES, please attach written explanation.	nent or counseling?
5. Was applicant ever known to suffer from any mental health disorders which required treatment If YES, please attach written explanation.	nt, counseling or medications?
6. Were applicant's final evaluations in every category rated satisfactory and/or above?photocopy of evaluation, together with written explanation.	If NO, please attach certified
Signed Nancy H. M. Clothly, M.D. NANCY H. McGLOTHLIN, REGISTRAR	
Dean )	
President Secretary of THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL (SEAL	OF COLLEGE)
Registrar Date MARCH 30,	, 19 <b>93</b>
Address:1301 CATHERINE ROAD, ANN ARBOR, MICHIGAN 48109	
Please return completed form DIRECT to: Arizona Board of Medical Examiners, 2001 W. Camelback Rd., Suite 300, Phoenix,	A TOPPER TO MEX
Revised 4/91	Arizona 85015



200 Jefferson S.E. Grand Rapids Michigan 49503 616 774-6090

May 20, 1993

The Board of Medical Examiners State Of Arizona 2001 West Camelback Road Suite 300 Phoenix, AZ 85015

Dear Sirs:

In response to your inquiry about Memie C. Burton, Jr., M.D., we are able to provide the following information.

Dr. Burton served as a Rotating Intern from July 1, 1963 through June 30, 1964 and as an Obstetrics and Gynecology resident from September 1, 1966, through August 30, 1969. During this time, he performed his duties and responsibilities in a satisfactory manner.

Sincerely,

Edward N. Peterson, M.D.

Director of Medical Education

ENP/jew 5928MEDED

RECEIVED BOME X.

accepted in dien of Form II
9/17/93 MeRSple

#### **FORM III**

#### POSTGRADUATE TRAINING CERTIFICATION

#### TO WHOM IT MAY CONCERN:

Revised 8/89

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed I participated in an approved post-graduate training program in the United States or Canada. This is your authoriting your files of record, favorable or otherwise, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, ST. WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be approved to the support of the supp	ty to release any information FATE OF ARIZONA, 2001 preciated.
Name: Menie Clifton Burton J. Mine Clefton J.	eston f. M.D.
Address: (Street)	
Date:	
(DO NOT DETACH)	
(This section to be completed by the office of the Administrator of the institution or program wherein completed (or will complete) a program of approved post-graduate training in the United States or Canada.)	the applicant satisfactorily
This is to certify that MeMIC C. BURTON Jr.  (Name of Applicant in Full)	, M.D. undertook and
satisfactorily completed a full term approved program of 36 months in the: BL0092T Memoly (Full Name and Complete)	the Address of Hospital)
1840 WELLTHY ST. SE, GRAND RADIOS, M; 4	19506
in the field of OBSTETRICS & GYNYCUTRY from 9/1/66 (Date)	to 6/30/kg R (Date/Anticipated Date)
and that the said program was approved for post-graduate training during that period by the Accreditation Co Education, or the Royal College of Physicians and Surgeons of Canada. YES NO	ouncil for Graduate Medical
1. Was applicant ever required to repeat any segment of training? If YES, which part(s)?	
2. Was applicant ever placed on probation, restricted or limited? If YES, please attach wr	ritten explanation.
3. Was there any reason not to continue applicant in the training program? VD If YES, please	attach written explanation.
4. Was applicant ever known to use or misuse any chemical substance or substances which requiring? If YES, please attach written explanation.	ired treatment or counsel-
<ol><li>Was applicant ever known to suffer from any mental health disorders which required treatment or YES, please attach written explanation.</li></ol>	counseling?
6. Were applicant's final evaluations in every category rated satisfactory and/or above? 45 If photocopy of evaluation, together with written explanation.	NO, please attach certified
	OF HOSPITAL)
Address 1840 WEALTLY ST. SE, GRAND RAPIDS MI 49506	indicate, if none)
Address 1840 WEALTRY ST. SE, GRAND RADIOS MI 49501 Date M	14m // ,19 93

Kathleen M. Wilbur Bureau Director



John Engler, Governor

#### **DEPARTMENT OF COMMERCE**

Arthur E. Ellis, Director

Bureau of Occupational and Professional Regulation North Ottawa Tower P.O. Box 30018 Lansing, Michigan 48909-7518

# MICHIGAN BOARD OF MEDICINE

#### CERTIFICATION OF EXAM SCORES

RE: Memie C. Burton, Jr., M.D.

I herby certify that the following are the true scores received by the aforementioned physician at an examination conducted by the Michigan Board of Medicine in Detroit, Michigan, on

Anatomy, Gross, Microscopic & Neur
Biological Chemistry
Bacteriology, Microbiology & Immun
Physiology
Pathology
Medicine, incl. Dermatology
Preventive Medicine & Public Health
Obstetrics & Gynecology
Materia Medica, Pharm & Therapeutics
Medical Jurisprudence
Eye, Ear, Nose & Throat
Surgery, incl. Anesth. & Radiology
Neurology & Psychiatry
Pediatrics
AVERAGE

Nora Wolfe/

MICHIGAN BOARD OF MEDICINE

ELLENS TOWN

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**UCSD** 

UNIVERSITY OF CALIFORNIA, SAN DIEGO

BERKELEY · DAVIS · IRVINE · LOS ANGELES · RIVERSIDE · SAN DIEGO · SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

PHYSICIAN ASSESSMENT AND CLINICAL EDUCATION PROGRAM (P.A.C.E. PROGRAM) SCHOOL OF MEDICINE VOICE: (619) 543-6770 FAX: (619) 543-2353

UNIVERSITY OF CALIFORNIA, SAN DIEGO MEDICAL CENTER 200 WEST ARBOR DRIVE, #8204 SAN DIEGO, CA 92103-8204 INTERNET: ucpace@ucsd.edu

January 29, 2002

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

RE: Memie C. Burton, Jr., M.D.

To Whom It May Concern:

I am writing you regarding Dr. Burton's recent participation in the UCSD Physician Assessment and Clinical Education (PACE) Program. On November 28, 2001, Dr. Burton underwent a 1-1/2 hour oral examination on obstetrical practices. Charles Nager, M.D., Professor of Clinical Reproductive Medicine, administered this examination to Dr. Burton. Enclosed is Dr. Nager's report.

Please do not hesitate to call our office at (619) 543-6770 if you have any questions or need any additional information.

Sincerely,

Peter A. Boal

Administrative Assistant **UCSD PACE Program** 

Enclosure:

Report from Charles Nager, M.D.



UCSD Healthcare, University of California, San Diego

December 3, 2001

Valerie Simmons, Esquire % Warner, Norcross & Judd 900 Fifth Third Bank Bldg. 111 Lyon, N.W. Grand Rapids, MI 49503

Re: M.C. Burton, Jr., M.D.

Dear Ms. Simmons:

On November 28, 2001 I performed a 1-1/2 hour oral examination of M.C. Burton, Jr., M.D. on obstetrical practices. We reviewed prenatal care, labor complications, and post-partum complications. Specifically, we addressed issues related to prenatal labs, prenatal diagnostic tests, Group B strep testing, management of latent phase, management of active phase, management of labor arrest disorders, shoulder dystocia, and post-partum hemorrhage.

Dr. Burton passed this obstetrical evaluation.

Sincerely,

Charles Nager, M.D.

Professor of Clinical Reproductive Medicine Department of Reproductive Medicine

noger, MD

Cc:

William Norcross, M.D.

Director, UCSD PACE Program

MC 8809

CN/d1

Janet Napolitano Governor

**Timothy C. Miller, J.D.** Executive Director

**Amanda J. Diehl, M.P.A., C.P.M.**Deputy Executive Director

Bernadette E. Phelan, Ph.D. Assistant Director



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

Robert P. Goldfarb, M.D., F.A.C.S.

William R. Martin, III, M.D. Vice-Chair

Douglas D. Lee, M.D. Secretary

April 12, 2006

Memie Burton, Jr. M.D.
RE: Case No: MD-05-0558
Dear Dr. Burton:
The Arizona Medical Board administratively closed this case after determining that:
The Board does not have jurisdiction because the physician is deceased.
X The case was opened in error. The Board has no jurisdiction over the licensee and/or the conduct involved.
The case cannot be completely investigated sufficiently to make a final determination due to lack of available evidence.
This malpractice settlement was previously reported and is the subject of a pending investigation.
This malpractice matter is still pending and the Board has not received a patient complaint.
This matter is currently being investigated under another case number.
Thank you for allowing the Board to review this matter.
Sincerely,
to to Mille

Timothy C. Miller, J.D. Executive Director

TCM/vb

CK 1188

#### ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2704 Website: www.azmd.gov

#### **DISPENSING PHYSICIAN ANNUAL RENEWAL FORM**

\*\* Please Type or Print \*\*

PHYSICIAN NAME: Memie Clifton Burton, MD

MD LICENSE #: 30399

SPECIALTY: 68 944

AZ MEDICAL BOADA



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

*5*771 W Eugie Glendale, AZ 85304

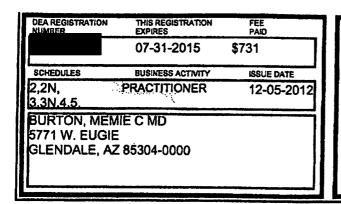
Schedule III Drugs Schedule IV Drugs Schedule V Drugs Prescription Only Drugs Prescription Devices

Dispensing location information correct  $\ \square$  Copy of DEA attached  $\ \square$  Remove this location

Physician's Signature:

Date:

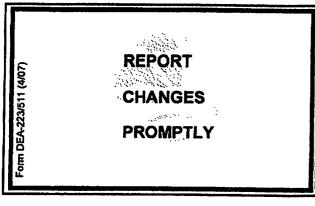
**ENTERED** 



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

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

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



### REQUESTING MODIFICATIONS TO YOUR REGISTRATION CERTIFICATE

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

- visit our web site at deadiversion.usdoj.gov or
   call our customer Service Center at 1-(800) 882-9839 or
   submit your change(s) in writing to:
  - Drug Enforcement Administration P.O. Box 28683 Washington, DC 20083

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

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

#736 P.015/018

#### ARIZONA MEDICAL BOARD

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

#### DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM \*\* Please Type or Print \*\*

PHYSICIAN NAME:	Memi	e C. Burton				MAR 18 20
LICENSE #: 30399 SF			PECIALTY: Obstetrics & Gy	neco	AZ MEDICAL &	
CHECK ONE: √ Initial Registration (\$200)			Renewal Registra	ation	(\$150)	
☐ Please list below ALI	L loca	ations where you will be disp	pensing	prescription drugs, devices an	d con	trolled substances.
그 사람이 그리아 얼마를 하는 것이 그리고 그리지 않는데 하는데 다른데 나를 다 했다.				ns of the prescription items which pensing of controlled substance		be dispensed from that location, any location.
A separate DEA lice	nse	must be submitted for EA	CHloc	SE NOTE cation where controlled subsing the registration period	tance	es will be dispensed and must
		be kept durie		ng the registration period		
PRIMARY PRACTICE				DEA# FOR THIS LOCAT		
3		Address I W. Eugie				Zip Code AZ 85304
		Number 63-4210		Fax Number		E Mail
Schedule II Drugs		Schedule III Drugs	X	Prescription-Only Drugs	Х	Nubain
Schedule IV Drugs X Schedule V Drugs X		Prescription Devices	Х			
ADDITIONAL PRACTI				DEA# FOR THIS LOCAT		
S	treet	Address		City/S	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			
	tion		page of	this form and place a che	ck m	21/13

Make checks or money orders payable to ARIZONA MEDICAL BOARD

Initial registration fee: \$200.00 per physician

For your convenience, we accept payments by Visa, MasterCard or American Express

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



Renewal registration fee: \$150.00 per physician

BURTON, MEMIE C MD 5651 N. 7TH STREET PHOENIX, AZ 85014-0000-000

Halalddinadddalladladladladladladladlad

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
	07-31-2015	\$731
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	12-05-2012
BURTON, MEM 5771 W. EUGIE		
GLENDALE, AZ	85304-0000	
	"Marsament"	

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

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

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#### CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE

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

NUMBER	EXPIRES	FEE PAID
	07-31-2015	\$731
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	12-05-2012

BURTON, MEMIE C MD 5771 W. EUGIE GLENDALE, AZ 85304-0000

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DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID		
	07-31-2015	\$731		
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE		
2,2N, 3,3N,4,5,	PRACTITIONER	12-05-2012		
BURTON, MEMIE C MD 5771 W. EUGIE GLENDALE, AZ 85304-0000				
	* Moraemen **			

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

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

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

# REPORT CHANGES PROMPTLY

## REQUESTING MODIFICATIONS TO YOUR REGISTRATION CERTIFICATE

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

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

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

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

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

Arizona Medical Board: License Renewal Questions						
Memie	Burton		2013	License # 30399	Professional Conduct	
Since your last renewal has licensure denied or rejected	nave you had an application for medical d by another state or province licensing board?	No				
	nas disciplinary or rehabilitative action been er licensing board, including other health	No				
	have any disciplinary actions, restrictions or u while participating in any type of training are provider?	No				
	have you been found in violation of a statute, mestic or foreign governmental agency?	No				
5. Since your last renewal had medical board or peer review	nave you been under investigation by any ew body?	No				
resulting in a revocation, su	have you had a medical license disciplined ispension, limitation, restriction, probation, lation during an investigation or entered into a lation?	No				
7. Since your last renewal, denied, suspended, or restr	have you had hospital privileges revoked, ricted?	No				
8. Since your last renewal, malpractice matter currently judgment against you?	have you been named as a defendant in a y pending or that resulted in a settlement or	No				
disciplinary action, including	have you been subjected to any regulatory g censure, practice restriction, suspension, ractice, imposed by any agency of the federal or	No				
	, have you had your authority to prescribe, dications limited, restricted, modified, denied, a federal or state agency?	No				
	, have you engaged or do you engage in the substance, habit-forming drug, or prescription					
	, have you been found guilty or entered into a ny, or misdemeanor involving moral turpitude in	No				

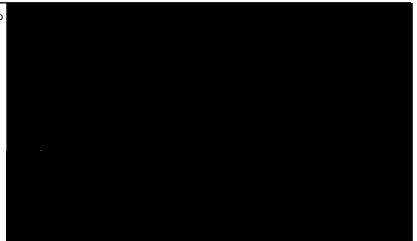
Arizona Medical Board: License Renewal Questions								
Memie	Burton	2013	License # 30399	Mental Health				
that impairs or limits your	al have you had or do you have a medical conditions ability to safely practice medicine including a rany psychotic disorder or substance abuse							
	al, have you consumed intoxicating beverages eing impaired or limited to exercise the judgment ofessional?							

	Arizona Medical Board:	Lice	nse Renev	val Questions	
Memie	Burton		2011	License # 30399	Professional Conduct
	ove you had any application for any or denied by any licensing authority?	No			
	ive you been refused or denied the privilege of ed for any professional licensure?	No			
3. Since your last renewal h license?	ave you voluntarily surrendered any healthcare	No			
4. Since your last renewal h	ave you had any healthcare license revoked?	No			
or are you currently under in license (other than by the Ari sanctioned by any healthcare	eve you been the subject of disciplinary action vestigation with regard to your healthcare zona Medical Board), have you been be licensing authority, healthcare association, realthcare staff of such facility?	No			
voluntarily or involuntarily res	ive your privileges been restricted, terminated, signed or withdrawn by any healthcare e association, licensed healthcare facility or ty?	No			
by any licensing agency (oth to any professional license?	as disciplinary action been taken against you er than the Arizona Medical Board) with regard -Disciplinary Action- includes, but is not limited lluntary or involuntary resignation or withdrawn.	No			
controlled substance authoris	ove you had a registration issued by a y (State or Federal) revoked, suspended, denied or have you surrendered or given up in	No			
pardoned or had a record ex	ove you been charged with or convicted, punged or vacated of a felony, misdemeanor ee explanation below) A -yes- answer is a diversion program.	No			
(including a nolo contendere	nave you been charged with or convicted plea or guilty plea) of a violation of any federal whether or not sentence was imposed or	No			
11. Since your last renewal hother than honorably from th	nave you been court martialed or discharged e armed service?	No			
	nave you been terminated from a healthcare r state government or the Federal government?	No			
received sanctions, including	nave you been convicted of insurance fraud or restrictions, suspension or removal from ency of the Federal government?	No			

#### **Arizona Medical Board: License Renewal Questions**

Memie Burton 2011 License # 30399 Mental Health

- 1. Since your last renewal, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?
- 2. Are you now being treated or since your last renewal have you been treated or for a drug or alcohol addiction or participated in a rehabilitation program? \*If in a confidential program in another state see explanation below
- 3. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1)behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice? See below for definition of ability to practice medicine.



# ARIZONA MEDICAL BOARD BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 3039	9 Renewal For	) 2: \$500 /\$850 (if po	estmarked 30 days after due d	nte)
Name: Memi C Bue-	TON TO (MD)			
PUBLIC ADDRESS & PHONE NUMBER	/c 1	No.	166 5	ĺ
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	4/10	DEN'Y	1200	
Phone # (602) 263 - 1200 Fax	#: 602 263	-1662	.[-200	<del></del>
E-Mail:				5/4/1
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Phone #:	•			
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Mobile #:				
AMERICAN BOARD OF MEDICAL SPECIALTY C			<del></del>	
			<del></del>	ato.
AMERICAN BOARD OF MEDICAL SPECIALTY C  Only certifications from ABMS will be shown in you  Field of Practice Code	ABMS Certified?	Please indicate exp	ration date or lifetime certification Date (or	-
AMERICAN BOARD OF MEDICAL SPECIALTY C	ır profile on the website.	Please indicate exp	ration date or lifetime certificate  Expiration Date (or indicate lifetime certificate)	-
AMERICAN BOARD OF MEDICAL SPECIALTY C  Only certifications from ABMS will be shown in you  Field of Practice Code  (see attached form for code)	ABMS Certified?	Please indicate exp	ration date or lifetime certification Date (or	-
AMERICAN BOARD OF MEDICAL SPECIALTY Conly certifications from ABMS will be shown in your Field of Practice Code (see attached form for code)	ABMS Certified?	Please indicate exp	ration date or lifetime certificate  Expiration Date (or indicate lifetime certificate)	-
AMERICAN BOARD OF MEDICAL SPECIALTY C  Only certifications from ABMS will be shown in you  Field of Practice Code (see attached form for code)  OBE:  REQUEST FOR CHANGE IN LICENSE STATUS:  INACTIVE STATUS (I have read and meet the requ	ABMS Certified?  (Y/N)	Practicing? (Y/N)	Expiration Date (or indicate lifetime certificate lifetime certificate lifetime certificate lifetime)	-
AMERICAN BOARD OF MEDICAL SPECIALTY C  Only certifications from ABMS will be shown in you  Field of Practice Code  (see attached form for code)  OBEF	ABMS Certified?  (Y/N)	Practicing? (Y/N)	Expiration Date (or indicate lifetime certificate lifetime certificate lifetime certificate lifetime)	-
AMERICAN BOARD OF MEDICAL SPECIALTY C  Only certifications from ABMS will be shown in you  Field of Practice Code (see attached form for code)  OBE  REQUEST FOR CHANGE IN LICENSE STATUS:  INACTIVE STATUS (I have read and meet the require  CANCELLATION (I have read and meet the require  I hereby certify, under penalty of perjury by my sig	ABMS Certified?  (Y/N)  direments for Inactive status ments to cancel my license anature below that all infe	Practicing? (Y/N)  as listed in the instruction on this formation on this formation.	Expiration Date (or indicate lifetime certifical indicate lifetime certifical lifetime) certifical lifetimes certi	ted)
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AMERICAN BOARD OF MEDICAL SPECIALTY C  Quly certifications from ABMS will be shown in your  Field of Practice Code (see attached form for code)  OBG  REQUEST FOR CHANGE IN LICENSE STATUS: INACTIVE STATUS (I have read and meet the require  CANCELLATION (I have read and meet the require  I hereby certify, under penalty of perjury by my sig  I have completed a minimum of 40 credit hours of my renewal as required by A.R.S. §32-1434 and  I have a written protocol in place for the secure secures.	ABMS Certified? (Y/N)  direments for Inactive status ments to cancel my license and accept the continuing medical education of A.A.C. § R4-16-101 storage, transfer and accept the continuing medical education of	Practicing? (Y/N)  as listed in the instruction on this forcation during the property of the p	Expiration Date (or indicate lifetime certification Date)  indicate lifetime certification certification Date (or indicate lifetime certification)  uctions)  crim is currently accurate a previous two calendar years	ted)
AMERICAN BOARD OF MEDICAL SPECIALTY C  Quly certifications from ABMS will be shown in your  Field of Practice Code (see attached form for code)  OBG  REQUEST FOR CHANGE IN LICENSE STATUS: INACTIVE STATUS (I have read and meet the require  CANCELLATION (I have read and meet the require  I hereby certify, under penalty of perjury by my sig  I have completed a minimum of 40 credit hours of my renewal as required by A.R.S. §32-1434 and  I have a written protocol in place for the secure significant protocol in place	ABMS Certified? (Y/N)  direments for Inactive status ments to cancel my license and accept the continuing medical education of A.A.C. § R4-16-101 storage, transfer and accept the continuing medical education of	Practicing? (Y/N)  as listed in the instruction on this forcation during the pass of the medical	Expiration Date (or indicate Infetime certification Date)  indicate Infetime certification of the certification of	nd
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AMERICAN BOARD OF MEDICAL SPECIALTY C  Only certifications from ABMS will be shown in your  Field of Practice Code (see attached form for code)  OBE  REQUEST FOR CHANGE IN LICENSE STATUS:  INACTIVE STATUS (I have read and meet the require  CANCELLATION (I have read and meet the require  I hereby certify, under penalty of perjury by my sig  I have completed a minimum of 40 credit hours of my renewal as required by A.R.S. §32-1434 and  I have a written protocol in place for the secure of my practice close as required by A.R.S. §32-3211.  I am a U.S. Citizen or U.S. National (If this listed approved supporting documents listed in Benefits" i.e. Birth Certificate, U.S. Passport, etc.	ABMS Certified? (Y/N)	Practicing? (Y/N)  as listed in the instruction on this forcation during the pass of the medical aubmit with your apport Citizenship and	Expiration Date (or indicate lifetime certification)  uctions)  critical lifetime certifications (or indicate lifetime certifications)  prim is currently accurate a previous two calendar years (or experience of my patients should be plication a copy of one of the Alien Status for State Publication Status for State Publication and publication according to the pub	nd said he sole
AMERICAN BOARD OF MEDICAL SPECIALTY CONTY certifications from ABMS will be shown in your Field of Practice Code (see attached form for code)  Coeff  REQUEST FOR CHANGE IN LICENSE STATUS: INACTIVE STATUS (I have read and meet the require CANCELLATION (I have read and meet the require I have certify, under penalty of perjury by my sign of my renewal as required by A.R.S. §32-1434 and I have a written protocol in place for the secure of my practice close as required by A.R.S. §32-3211  I am a U.S. Citizen or U.S. National (If this listed approved supporting documents listed in Benefits" i.e. Birth Certificate, U.S. Passport, etc. I am NOT a U. S. Citizen or U.S. National (application "Arizona Statement of Citizenship and Company of Company of Citizenship and Company of Citizenship and Company of Citizenship and Company of Citizenship and	ABMS Certified?  (Y/N)  ABMS C	Practicing? (Y/N)  as listed in the instruction on this forceation during the pass of the medical abmit with your apport Citizenship and must download, or Public Benefits" (or	Expiration Date (or indicate lifetime certification)  uctions)  crim is currently accurate a previous two calendar years records of my patients should be also be also between the complete and submit with we complete and submit	nd said file for the form
AMERICAN BOARD OF MEDICAL SPECIALTY CONTY certifications from ABMS will be shown in your Field of Practice Code (see attached form for code)  COCE  REQUEST FOR CHANGE IN LICENSE STATUS:  INACTIVE STATUS (I have read and meet the require CANCELLATION (I have read and meet the require I have completed a minimum of 40 credit hours of my renewal as required by A.R.S. §32-1434 and I have a written protocol in place for the secure of my practice close as required by A.R.S. §32-3211.  I am a U.S. Citizen or U.S. National (If this listed approved supporting documents listed in Benefits" i.e. Birth Certificate, U.S. Passport, etc.  I am NOT a U. S. Citizen or U.S. National (I	ABMS Certified?  (Y/N)  ABMS C	Practicing? (Y/N)  as listed in the instruction on this forceation during the pass of the medical abmit with your apport Citizenship and must download, or Public Benefits" (or	Expiration Date (or indicate lifetime certification)  uctions)  crim is currently accurate a previous two calendar years records of my patients should be also	nd said fine for the form
AMERICAN BOARD OF MEDICAL SPECIALTY CONTY certifications from ABMS will be shown in your Field of Practice Code (see attached form for code)  Coeff  REQUEST FOR CHANGE IN LICENSE STATUS: INACTIVE STATUS (I have read and meet the require CANCELLATION (I have read and meet the require I have certify, under penalty of perjury by my sign of my renewal as required by A.R.S. §32-1434 and I have a written protocol in place for the secure of my practice close as required by A.R.S. §32-3211  I am a U.S. Citizen or U.S. National (If this listed approved supporting documents listed in Benefits" i.e. Birth Certificate, U.S. Passport, etc. I am NOT a U. S. Citizen or U.S. National (application "Arizona Statement of Citizenship and Company of Company of Citizenship and Company of Citizenship and Company of Citizenship and Company of Citizenship and	ABMS Certified? (Y/N)	Practicing? (Y/N)  as listed in the instruction on this forceation during the pass of the medical abmit with your apport Citizenship and must download, or Public Benefits" (or	Expiration Date (or indicate lifetime certification)  uctions)  crim is currently accurate a previous two calendar years records of my patients should be also	nd said fine for the form

Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES		NO.Z
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	YES		NO D
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES		NO Ø
4. Since your last renewal have you had any healthcare license revoked?	YES		NO Z
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 Z
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		MOM
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 EX
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	0	NO \$Z
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	YES		NO DC
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 B
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		NOV
· · · · · · · · · · · · · · · · · · ·			

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.

License Number:

30399

#### CONFIDENTIAL

Physical/Mental Health and Substance Abuse

- Since your last renewal have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?
- 2. Are you now 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
  - 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 modicine 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: Wemic C

License Number:ನ

30399

Pd C

Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES 🗆	NO 🕱
<ol><li>Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?</li></ol>	YES 🗆	NO/\$
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES 🗆	NO DE
4. Since your last renewal have you had any healthcare license revoked?	YES 🗆	NO DEC
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 🗆	ио 💆
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 D
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# ARIZONA MEDICAL BOARD 2007 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD LIC#: 3039 Memic C. Burton Jr. MD  Renewal Fee: \$500 \$850 (if postmerhard after 10/03/2007)  Please review and make corrections as necessary in office Address/FRINCIPAL FOACE of Business  OFFICE ADDRESS/FRINCIPAL FLACE OF BUSINESS  INC. 1 18 Mall:	2007 BIENNIAL MD LICEN	SE RENEWAL APPLI	CATION	
Please review and make orrections as necessary. IN OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS  PROBLE ADDRESS & PRIONE NUMBER  42) 2 N 16th ST PRIONE NUMBER  Phone # (602) 263-1:000 Fax #: (602) 263-1:662 Phone #: Fax #	A7 MD Lic#: 30399 Mamie C Burton Ir MD	Penewal Foo: \$500, \$850 (if a	ostmarked after 10	(/03/2007)
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Phone #: (602) 263-1:00 Fax #: (602) 263-1652 Phone #: Fax #:  E-Mail:  HOME ADDRESS  ADITONA MEDICAL  BOATIONS  Phone #: Fax #: Phone #: Fax #:  E-Mail:  Mobile #: (Opnons)  AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:  Only certifications from AEMS will be shown in your profile on the website. Please indicate extinction for the practical pr				
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HOME ADDRESS  Service 2 modeling oddress:  Phone #: Fax #: Phone #: Fax #: Phone #: Fax #:  E-Mail: Mobile #: (Optional)  AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:  Only certifications from AEMS with a shown in your profile on the website. Please indicate expiration date or lifetime certificate certifier.  Practical Pract	E-Mail:	E-Mail:		
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Phone #: Fax #: Phone #: Fax #: Phone #: Fax #:  E-Mail:  Mobile #: Mobile #: (Optional)  AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:  Only certifications from AEMS will be shown in your profile on the website. Please indicate excirctions date or lifetime certificate certificate.  OBC Practicing Practicing Certification will be shown in your profile on the website. Please indicate excirctions of the practicing Practicinal Practicinal Report Institute Sequence Institute Status and the status as listed in the instructions of the certification will be removed from your profile on the website.  REQUEST FOR CHANGE IN LICENSE STATUS:  In INACTIVE STATUS (I have read and meet the requirements for Inactive status 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. §32-1934 and A.A.C. § 48-16-101  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. §32-321.  Signature of Licensee (Signature by A.R.S. §32-321.  Manual A.R. S.	SAME DE Mailing Oddress		THES	SUPERATION
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<ul> <li>CANCELLATION (I have read and meet the requirements to cancel my license as listed in the instructions)</li> <li>I hereby certify, under penalty of perjury by my signature below that all information on this form is currently accurate and:         <ul> <li>I am a U.S. Citizen or a qualified/registered alien</li> <li>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</li> <li>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.</li> </ul> </li> <li>Signature of Licensee (Signature stamp will not be accepted)         <ul> <li>Date</li> </ul> </li> <li>30399 Memic C. Burton Jr., MID</li> </ul>	☐ INACTIVE STATUS (I have read and meet the requirements for	or Inactive status as listed in the in:	structions)	
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30399 Memie C. Burton Jr., MD	Many Control of	11/09		
	Signature of Licensee (Signature stamp will not be accepted)	Date	_	THE PRINCES
SEE REVERSE SIDE I		CE 1	<u></u>	ENTERED
	FA	GL 1	SEE REVER	Dr. Zimira

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	иоЖ
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES	NO DY
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	ио 🙇
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 D
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 \Z
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 À
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 টু <b>Հ</b>
1.0. Since your last renewal have you been charged with or convicted (including a noio 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 <b>/</b> 2(
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	YES	ио 🖂
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	МОЖ
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 ÇX

**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 decuments, 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.

INITIALS REQUIRED HOB

30399 Memie C. Burton Jr., MD

#### CONFIDENTIAL

Physical/Mental Health and Substance Abuse

- Since your last renewal have you been diagnosed, treated or admitted to a
  hospital or other facility for the treatment of bi-polar disorder,
  schizophrenia, paranoia or any psychotic disorder?
- 2. Are you now 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:
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  - 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.

30399 Memie C. Burton Jr., MD

INITIALS REQUIRED MES

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#### 2005 BIENNIAL MD LICENSE RENEWAL APPLICATION

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

# 2003 BIENNIAL MD LICENSE RENEWAL APPLICATION CME



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<ol><li>Other than in Arizon</li></ol>	a, since your last re	newal have you had a medi	cal license disciplin	ed resulting i	n revocation, suspensi	ion, limitation, restriction, pro	obation, voluntary
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11. Since your last renev	wal, has à malpractio	ce lawsuit resulted in a sett	lement or judgment	t against you	?	*	□ Yes M No
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