



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

FOR BOARD USE DO NOT USE THIS SPACE

Attach an approximate 2 1/2" x 3" photograph of passport quality of your head and shoulders only. Photo must have been taken within the last 50 days and be signed in ink across the lower portion of the front side.

Proof photos, negatives, Polaroid type photos are not acceptable.

Date Application Sent: \_\_\_\_\_

Date Application Received: 1/31/02

- ENDORSEMENT
USMLE
SPEX

13818

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

INFORMATION

All candidates shall provide satisfactory evidence that he/she:

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

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 Applications not fully complete within one year from date of notification of deficiency in application are considered withdrawn.

APPLICATION INSTRUCTIONS (Read Carefully)

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

- 1. Evidence of name and date of birth: a certified copy of birth certificate or other documentary evidence for consideration i.e., Visa, Passport; baptismal certificate, alien resident card, or naturalization certificate.
2. Certified evidence of any legal name changes other than that shown on certificates filed in accordance with paragraph 1 above, (e.g., marriage certificate). Proof of foreign birth of American parents.
3. A complete list of all your hospital affiliations and employment for the five years prior to filing this application.
4. Cashier's Check or Money Order in U.S. Funds (personal checks not accepted), covering the statutory fee prescribed in statute and rule.
5. Credentials submitted in foreign languages shall have affixed thereto a certified translation into English.
6. Separated or mutilated Applications are not acceptable and will require refileing.
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 1/2 inches by 11 inches in size.

**APPLICATION and Initial Registration**

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

1. Present Legal Name BURTON Memio CLIFTON Je  
 (Last) (First) (Middle) (Maiden)

(a) Other names used: None

2. Office Address: 4212 No 16<sup>th</sup> St Phoenix AZ 85028 (602) 2631550  
 (No. [Redacted]) (Zip/Post Code) (Area code/Phone)

3. City and State of Birth: [Redacted]

4. In what states or provinces have you applied for or been granted license or registration? If more than two, attach separate listing. If license not issued, so state.

(a) MICHIGAN 1963 granted 25923  
 (State Board) (Date of Application) (Result) (Certificate No.)

1963 WRITTEN  
 (Date Issued) (Specify if by Written Examination or on Credentials)

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

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

Please answer questions on line at right.

5. Have you ever had an application or medical license denied or rejected by another state/province licensing board? no

6. Has any disciplinary or rehabilitative action ever been taken against you by any state licensing board, including other health professions? Examples of actions include but are not limited to reprimand, censure, probation, restriction, limitation, suspension, stipulation, written consent agreement or revocation. YES see attached letter

7. Have any disciplinary actions, restrictions, limitations ever been taken against you while you were participating in any type of training program or by any health care provider? no

8. Have you ever been found to be in violation of any statute, rule or regulation of any domestic or foreign governmental agency? no

9. Has there been any disciplinary action initiated against you by or through any medical board or association? no

10. Are you currently under investigation by any medical board or peer review body? no

11. Have you ever had a medical license disciplined resulting in a: revocation, suspension, limitation, restriction, probation, voluntarily surrender, cancellation during an investigation or entered into a consent agreement or stipulation? YES, same as #6

12. Have you ever had hospital privileges revoked, denied, suspended or restricted in any way? no

13. Have you ever been named as a defendant in any malpractice matter currently pending or which resulted in a settlement or judgement against you? no

14. Have you ever been convicted of insurance fraud or received sanctions, including restriction, suspension or removal from practice, imposed by any agency of the federal government? no

15. Have you ever had your ability to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered or revoked by a federal or state agency? no

16. Are you currently engaged in the illegal use of any controlled substance, habit forming drug or prescription medication? \_\_\_\_\_
17. Have you consumed intoxicating beverages resulting in your present ability to exercise the judgement and skills of a medical professional being impaired or limited? \_\_\_\_\_
18. Have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? no

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

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

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

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

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

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

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

21. Name and location of Medical School: Univ. of Michigan Ann Arbor, Mich

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

- 1963-64 Internship - St Marys Hospital, 200 Jefferson, Grand Rapids, Mich 49503
- 1964-66 - U.S. Navy - Medical Officer: Great Lakes Illinois
- 1966-69 - Obstetrical residency - Blodgett St Marys Combined Prog - 200 Jefferson, SE 1800 Wealthy, Grand Rapids, Mich 49503

23. Are you certified by any of the American Board of Medical Specialties? Yes, OB/GYN

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

At Phoenix Indian Health, Phoenix AZ	from 1993	to present
(City) (State)		
At Grand Rapids, Mich	from 1969	to 1993
(City) (State)		
At _____	from _____	to _____
(City) (State)		
At _____	from _____	to _____
(City) (State)		

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

Signature of Applicant Memie C. Burton, Jr., M.D.

STATE OF ARIZONA

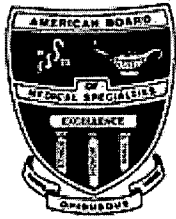
County of MARICOPA



Subscribed and sworn to before me this 6<sup>th</sup> day of February 2002

Notary Signature Colleen Olsen My Commission expires 6-10-05  
(NOTARY PUBLIC)

FOR OFFICIAL USE ONLY	
Application Processed by	<u>dj <del>3502</del></u>
Application Checked by	<u>ma</u>
Application Approved	<u>5/23 20 02</u> By <u>Per Dr. [Signature]</u>
License Issued	<u>ma 6/3/02</u>
License Number	<u>30399</u>

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## Certifications

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**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  
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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 Burton, Jr., M.D. *Memie Clifton Burton, Jr.*, M.D.  
(Please Print or Type)

Address: [Redacted] (Street)

Date: 3/15/93

(DO NOT DETACH)

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

This is to certify that MEMIE CLIFTON BURTON, JR.  
(Full Name of Student)

whose photograph is attached hereto, was granted the degree of DOCTOR OF MEDICINE by

THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL on JUNE 8, 19 63,  
(Full Name of School or College of Medicine as it appears on the Applicant's Medical degree diploma)

that the date of his/her matriculation in medical school was SEPTEMBER 21, 19 59; and that he/she attended 4 YEARS full courses of medical lectures comprising 8 1/2 months each as verified by the attached certified copy of his/her transcripts.  
(Number) (Number)

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 written explanation.
3. Was there any reason not to continue applicant in the training program? \_\_\_\_\_ 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? \_\_\_\_\_ If YES, please attach written explanation.
5. Was applicant ever known to suffer from any mental health disorders which required treatment, counseling or medications? \_\_\_\_\_ If YES, please attach written explanation.
6. Were applicant's final evaluations in every category rated satisfactory and/or above? \_\_\_\_\_ If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed Nancy H. McGlothlin, M.D.  
**NANCY H. MCGLOTHLIN, REGISTRAR**

Dean }  
President }  
Secretary } of THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL  
Registrar }

(SEAL OF COLLEGE)

Date MARCH 30, 1993

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, Arizona 85015

RECEIVED BOARD OF MEDICAL EXAMINERS  
MAR 12 1993

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.*

Edward N. Peterson, M.D.  
Director of Medical Education

ENP/jew  
5928MEDED

*accepted in lieu of Form II  
9/17/93 MURZPLE*

RECEIVED B.O.M.E.X.  
MAY 24 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, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

Name: Memie Clifton Burton Jr., M.D. Memie Clifton Burton Jr., M.D.  
(Please Print or Type)

Address: [Redacted] [Redacted]  
(Street)

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 MEMIE C. BURTON JR., M.D. undertook and  
(Name of Applicant in Full)  
satisfactorily completed a full term approved program of 36 months in the: BLOODETIP MEMORIAL MEDICAL CENTER  
(Number) (Full Name and Complete Address of Hospital)

1840 WEALTHY ST. SE, GRAND RAPIDS, MI 49506  
in the field of OBSTETRICS & GYNCOLOGY from 9/1/66 to 9/1/69 or 8/30/69 RW  
(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  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 RULEN L. TUPPER MD  
Title DIRECTOR, MEDICAL EDUCATION  
Address 1840 WEALTHY ST. SE, GRAND RAPIDS, MI 49506

(SEAL OF HOSPITAL)  
(So indicate, if none)  
Date MAY 11, 19 93  
RECEIVED





John Engler, Governor

DEPARTMENT OF COMMERCE

Arthur E. Ellis, Director

Kathleen M. Wilbur  
Bureau 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 hereby 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.....	87%
Biological Chemistry.....	80%
Bacteriology, Microbiology & Immun.....	94%
Physiology.....	86%
Pathology.....	88%
Medicine, incl. Dermatology.....	79%
Preventive Medicine & Public Health.....	90%
Obstetrics & Gynecology.....	80%
Materia Medica, Pharm & Therapeutics.....	91%
Medical Jurisprudence.....	80%
Eye, Ear, Nose & Throat.....	90%
Surgery, incl. Anesth. & Radiology.....	92%
Neurology & Psychiatry.....	88%
Pediatrics.....	85%
 AVERAGE.....	 86.7%

*Nora Wolfe*

Nora Wolfe  
MICHIGAN BOARD OF MEDICINE



RECEIVED  
APR - 5 93



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](mailto: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.

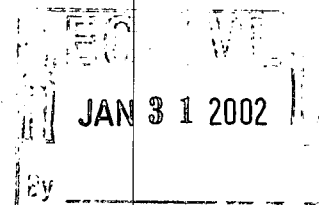
Please do not hesitate to call our office at (619) 543-6770 if you have any questions or need any additional information.

Sincerely,

A handwritten signature in cursive script that reads "Peter A. Boal".

Peter A. Boal  
Administrative Assistant  
UCSD PACE Program

Enclosure: Report from Charles Nager, M.D.





**UCSD Medical Center**

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, MD*

Charles Nager, M.D.  
Professor of Clinical Reproductive Medicine  
Department of Reproductive Medicine

Cc: William Norcross, M.D.  
Director, UCSD PACE Program  
MC 8809

CN/dl

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



## 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

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

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.

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,

Timothy C. Miller, J.D.  
Executive Director

TCM/vb

OK 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: OB/GYN

RECEIVED  
JUN 05 2013  
AZ MEDICAL BOARD

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

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

**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

5771 W Eugie  
Glendale, AZ 85304

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

Dispensing location information correct     Copy of DEA attached     Remove this location

Physician's Signature: Memie Clifton Burton Date: 6/3/2013

 ENTERED

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[REDACTED]	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		

**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 858) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

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

Form DEA-223/511 (4/07)

**REPORT  
CHANGES  
PROMPTLY**

**REQUESTING MODIFICATIONS TO YOUR REGISTRATION CERTIFICATE**

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

1. visit our web site at [deadiversion.usdoj.gov](http://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 28683  
 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: -----

Handwritten initials and date: 200-18

### 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: Memie C. Burton

LICENSE #: 30399

SPECIALTY: Obstetrics & Gynecology

RECEIVED  
MAR 18 2013  
AZ MEDICAL BOARD

CHECK ONE:     Initial Registration (\$200)                       Renewal Registration (\$150)

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

#### PLEASE NOTE

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

#### PRIMARY PRACTICE LOCATION:

#### DEA # FOR THIS LOCATION:

Street Address 5771 W. Eugie				City/State/Zip Code Glendale, AZ 85304			
Phone Number 602-263-4210				Fax Number 602-604-0159		E Mail [REDACTED]	
Schedule II Drugs		Schedule III Drugs	X	Prescription-Only Drugs	X	Nubain	
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices	X		

#### ADDITIONAL PRACTICE LOCATION:

#### DEA # FOR THIS LOCATION:

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

\*\*\*\* List any additional locations on the 2<sup>nd</sup> page of this form and place a check mark here:

Physician's Signature: *Memie C. Burton, MD* Date: 2/21/13

Initial registration fee: \$200.00 per physician

Renewal registration fee: \$150.00 per physician

Make checks or money orders payable to ARIZONA MEDICAL BOARD

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

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

ENTERED

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



DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[REDACTED]	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		

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

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

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

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

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
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BURTON, MEMIE C MD 5771 W. EUGIE GLENDALE, AZ 85304-0000		

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DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[REDACTED]	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		

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

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

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

Form DEA-223/511 (4/07)

**REPORT  
 CHANGES  
 PROMPTLY**

REQUESTING MODIFICATIONS TO YOUR  
 REGISTRATION CERTIFICATE

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

1. visit our web site at [deadiversion.usdoj.gov](http://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

1. Since your last renewal have you had an application for medical licensure denied or rejected by another state or province licensing board?

No

2. Since your last renewal has disciplinary or rehabilitative action been taken against you by another licensing board, including other health professions?

No

3. Since your last renewal have any disciplinary actions, restrictions or limitations taken against you while participating in any type of training program or by any health care provider?

No

4. Since your last renewal have you been found in violation of a statute, rule, or regulation of any domestic or foreign governmental agency?

No

5. Since your last renewal have you been under investigation by any medical board or peer review body?

No

6. Since your last renewal, have you had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation during an investigation or entered into a consent agreement or stipulation?

No

7. Since your last renewal, have you had hospital privileges revoked, denied, suspended, or restricted?

No

8. Since your last renewal, have you been named as a defendant in a malpractice matter currently pending or that resulted in a settlement or judgment against you?

No

9. Since your last renewal, have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government?

No

10. Since your last renewal, have you had your authority to prescribe, dispense, or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency?

No

11. Since your last renewal, have you engaged or do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication?

No

12. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state?

No

## Arizona Medical Board: License Renewal Questions

Memie

Burton

2013

License # 30399

Mental Health

1. Since your last renewal have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine including a diagnosis or treatment for any psychotic disorder or substance abuse disorder?

2. Since your last renewal, have you consumed intoxicating beverages resulting in your ability being impaired or limited to exercise the judgment and skills of a medical professional?



## Arizona Medical Board: License Renewal Questions

		2011	License # 30399	Professional Conduct
1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	<b>No</b>			
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	<b>No</b>			
3. Since your last renewal have you voluntarily surrendered any healthcare license?	<b>No</b>			
4. Since your last renewal have you had any healthcare license revoked?	<b>No</b>			
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?	<b>No</b>			
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?	<b>No</b>			
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.	<b>No</b>			
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?	<b>No</b>			
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.	<b>No</b>			
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?	<b>No</b>			
11. Since your last renewal have you been court martialled or discharged other than honorably from the armed service?	<b>No</b>			
12. Since your last renewal have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	<b>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?	<b>No</b>			

## 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#: ~~30339~~ 30399

Renewal Fee: \$500 /\$850 (if postmarked 30 days after due date)

Name: Memie C. Burton, Jr. MD

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



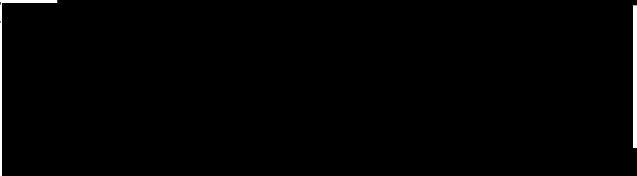
4212 No. 16th St.  
Phoenix, AZ 85016  
(602) 263-1200

Phone #: (602) 263-1200

Fax #: 602 263-1662

E-Mail:

MA

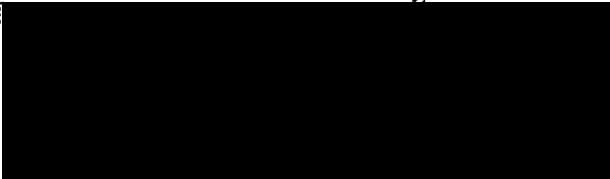


RECEIVED

AUG 19 2009

ARIZONA MEDICAL BOARD

HOME



Phone #:

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 certificate)
DBCF	Y	Y	Lifetime

### REQUEST FOR CHANGE IN LICENSE STATUS:

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

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

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

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

Memie C. Burton, Jr.  
Signature of Licensee (Signature stamp will not be accepted)

8/18/09

Date

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
4. Since your last renewal have you had any healthcare license revoked?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
11. Since your last renewal have you been court martialled or discharged other than honorably from the armed service?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>

**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: Memie C. Burton, Jr.

License Number: 30399

Signature: Memie C. Burton, Jr.

30399

**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?	
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?	
<b>Ability to practice medicine is to be construed to include all of the following:</b>	
<ol style="list-style-type: none"> <li>1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;</li> <li>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</li> <li>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.</li> </ol> <p>"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.</p>	

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: Memic C. Burtov Jr.  
 Signature: Memic C. Burtov Jr. PAGE 3

License Number: 30339  
30399



Pd CC

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
4. Since your last renewal have you had any healthcare license revoked?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>

### ARIZONA MEDICAL BOARD 2007 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 30399 Memie C. Burton Jr., MD	Renewal Fee: \$500 \$850 (if postmarked after 10/03/2007)
<b>CURRENT INFORMATION</b>	<b>CORRECTIONS</b>
Please review and make corrections as necessary. <sup>TM</sup>	
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER 4212 N 16th St Phoenix AZ 85016	OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
Phone #: (602) 263-1700 Fax #: (602) 263-1662	Phone #: Fax #:
E-Mail: [REDACTED]	E-Mail:
MAILING ADDRESS [REDACTED]	MAILING ADDRESS
HOME ADDRESS Same as mailing address	HOME ADDRESS
Phone #: [REDACTED] Fax #: [REDACTED]	Phone #: Fax #:
E-Mail:	E-Mail:
Mobile #:	Mobile #: (Optional)

RECEIVED

JUL 18 2007

ARIZONA MEDICAL BOARD  
BUSINESS OPERATIONS

**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 expiration date or lifetime certificate.*

DBG	Certified?		Practicing?		Expiration Date	Initials Required
	Y	N	Y	N		
	Y	N	Y	N	Lifetime	KCS

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

**REQUEST FOR CHANGE IN LICENSE STATUS:**

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

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

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

*Memie C. Burton Jr.* 7/17/07  
 Signature of Licensee (Signature stamp will not be accepted) Date  
 30399 Memie C. Burton Jr., MD

ENTERED

SEE REVERSE SIDE

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
4. Since your last renewal have you had any healthcare license revoked?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
11. Since your last renewal have you been court martialled or discharged other than honorably from the armed service?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>

**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.

30399 Memie C. Burton Jr., MD

INITIALS REQUIRED

MCB

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?	
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.

30399 Memie C. Burton Jr., MD

INITIALS REQUIRED

*MCB*

pd cc

### 2005 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic #: 30399 Memie C. Burton Jr., MD

Renewal Fee: \$500

\$850 (if postmarked after 10/03/2005)

<b>OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS &amp; PHONE NUMBER</b> 4212 N 44th St Phoenix AZ 85018-4219		<b>OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS</b>	
Phone #: (602) 263-1200	Fax #: 602 263-1662	Phone #:	Fax #:
E-Mail:		E-Mail:	
<b>MAILING ADDRESS</b>		<b>MAILING ADDRESS</b>	
<b>HOME ADDRESS</b>		<b>HOME ADDRESS</b>	
Phone #:	Fax #:	Phone #:	Fax #:
E-Mail:		E-Mail:	
		Cell Phone #: (Optional)	

RECEIVED  
 AUG 23 2005  
 BY:

**AMERICAN BOARD CERTIFICATIONS AND FIELD OF PRACTICE:**

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

Org	Certified?	Practicing?
	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)  Yes  No
7. Do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication?  Yes  No
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?  Yes  No
9. Have you been denied a license in another state? If yes, State \_\_\_\_\_ Date of Denial \_\_\_\_\_ Reason for Denial \_\_\_\_\_  Yes  No
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? If yes, please attach an explanation and applicable court docket. See instructions on back.  Yes  No
11. Since your last renewal, has a malpractice lawsuit resulted in a settlement or judgment against you?  Yes  No

*on file*

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 maximum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § 14-16-101.

Signature of Licensee (Signature stamp will not be accepted)

8/14/2005  
Date

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

**ARIZONA MEDICAL BOARD  
2003 BIENNIAL MD LICENSE RENEWAL APPLICATION**

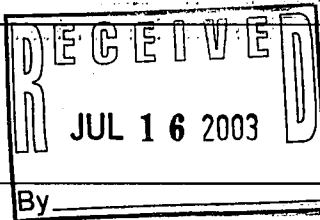
CME  
cc

AZ MD Lic#: 30399 Memie C. Burton Jr., MD

Renewal Fee: **\$500**

**\$850** (if postmarked after 10/03/2003)

CURRENT INFORMATION <small>Please review and make corrections as necessary →</small>	CORRECTIONS
<b>OFFICE/ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS &amp; PHONE NUMBER</b> 4212 N 44th St Phoenix AZ 85018-4219	<b>OFFICE/ADDRESS/PRINCIPAL PLACE OF BUSINESS</b>
Phone #: (602) 263-1200 Fax #:	Phone #: Fax #:
E-Mail: [REDACTED]	E-Mail:
<b>MAILING ADDRESS</b> [REDACTED]	<b>MAILING ADDRESS</b>
<b>HOME ADDRESS</b> [REDACTED]	<b>HOME ADDRESS</b>
Phone #: [REDACTED] Fax #:	Phone #: Fax #:
E-Mail: [REDACTED]	E-Mail:
	Cell Phone #: (Optional)



**AMERICAN BOARD CERTIFICATIONS AND FIELDS OF PRACTICE:**

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

	Certified?	Practicing?		Certified?	Practicing?
OBG	Y	N	Make corrections if necessary		YES

**I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:**

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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
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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. If malpractice cases are reported, please include: the case number, venue, plaintiff name, and attorney names/addresses/phone numbers.**

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

Signature of Licensee (Signature stamp will not be accepted)

7/11/03  
Date



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