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

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

FOR BOARD USE
DO NOT USE THIS SPACE

Date Application Sent: JAN 2 5 2001

Date Application Received: _____

☐ ENDORSEMENT
☐ USMLE
☐ SPEX

14609

COMPLETED BY THE APPROPRIATE AGENCY AND RETURNED DIRECTLY TO THIS BOARD

INFORMATION

All candidates shall provide satisfactory evidence that he/she:

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

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 Applications not fully complete within one year from date of notification of deficiency in application are considered withdrawn.

APPLICATION INSTRUCTIONS
(Read Carefully)

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

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

UNITED STATES OR CANADIAN MEDICAL SCHOOL GRADUATES and GRADUATES OF MEDICAL SCHOOLS LOCATED OUTSIDE THE UNITED STATES OR CANADA will forward Forms numbered I, II, III, [redacted], and IV as may be applicable, to the appropriate agency with the request that they be completed and returned to the Arizona Board of Medical Examiners.

APPLICATION and Initial Registration

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

1. Present Legal Name *Seletz, M.D.* (Last) *Josepha* (First) *Inez* (Middle) _____ (Maiden)

   (a) Other names used: *n/a*

2. Office Address: *10150 National Blvd.* (No.) (Street) *Los Angeles* (City) *CA* (State) *90034* (Zip Code) *310-841-2082* (Phone)

3. City and State of Birth [redacted] Month, Day and Year of Birth [redacted]

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

   (a) *California* (State Board) *08/29/77* (Date of Application) *Active* (Result) *G35414* (Certificate No.)

   08/29/97 (Date Issued) *Written Examination* (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)

5. Have you ever had an application or medical license denied or rejected by another state/province licensing board? *No* (Answer)
6. Has any disciplinary or rehabilitative action ever been taken against you by any state licensing board, including other health professions? Examples of actions include but are not limited to reprimand, censure, probation, restriction, limitation, suspension, stipulation, written consent agreement or revocation. *No* (Answer)
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* (Answer)
8. Have you ever been found to be in violation of any statute, rule or regulation of any domestic or foreign governmental agency? *No* (Answer)
9. Has there been any disciplinary action initiated against you by or through any medical board or association? *No* (Answer)
10. Are you currently under investigation by any medical board or peer review body? *No* (Answer)
11. Have you ever had a medical license disciplined resulting in a: revocation, suspension, limitation, restriction, probation, voluntarily surrender, cancellation during an investigation or entered into a consent agreement or stipulation? *No* (Answer)
12. Have you ever had hospital privileges revoked, denied, suspended or restricted in any way? *No* (Answer)
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? *Yes* (Answer)
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* (Answer)
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* (Answer)

16. Are your currently in engaged in the ille[redacted]use of any controlled substance, habit formi[redacted] drug or prescription medication? [redacted] (Answer)

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

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* (Answer)

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

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

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 abreas of medical developments; and

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without th 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 o 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, menta retardation, emotion or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug-addiction and alcoholism.

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

In the event the response to question 19 and/or 20 is yes, you must file with the application a detailed written narrative statemen 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 physica examination, consultation report(s), discharge summary(ies) from the hospital/rehabilitation center, and a statement from you attending physician(s) or treating therapist setting forth your diagnosis, prognosis and recommendations for continuing care, treatmen and supervision.

21. Name and location of Medical School: *Temple University School of Medicine Philadelphia Pennsylvania*

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

San Francisco General Hospital *1001 Petrero Ave.* *San Francisco CA* *94110* *07/76-06/77 Rotating Intern*

Kaiser Permanente *4900 Sunset Blvd.* *Los Angeles CA* *90027* *07/77-06/81 Ob/Gyn Residency*

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

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

At *Preparing and waiting for Internship to begin* *Relocating to CA* from *05/76* to *06/76*
(City) (State)

At *Rotating intern / San Francisco General Hospital* *San Francisco CA* from *07/76* to *06/77*
(City) (State)

At *OB/GYN Physician / Kaiser Permanente* *Los Angeles CA* from *07/77* to *06/81*
(City) (State)

At *See attached* from to
(City) (State)

The applicant *Joseph Inez Seletz, 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 Joseph Inez Seletz, M.D.

(NOTARY SEAL)

KLAMARIA A. GROGAN
Commission # 1299809
Notary Public - California
Los Angeles County
My Comm. Expires May 3, 2005

STATE OF California
County of Los Angeles

Subscribed and sworn to before me this 25 day of August 20 02

Notary Signature Klamaria A. Grogan (NOTARY PUBLIC) My Comission expires May 3, 2005

FOR OFFICIAL USE ONLY

Application Processed by dj 11-4-02
Application Checked by JR 11/21/02 Adm Complete
Application Approved 11/22 2002 By Shelly Somerjust
License Issued 12/13/02 TRS
License Number 31032

[redacted]

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
http://www.docboard.org/bomex

RECEIVED
SEP 24 2002
Office of Faculty & Student Records
TEMPLE UNIVERSITY
SCHOOL OF MEDICINE

RECEIVED
OCT 07 2002
By

Form 2
Medical College Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the medical school granting the medical degree. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECT** to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258. Your prompt response will be appreciated.

Name: *Josepha* *Seletz*, M.D.

See Authorization (Signature) *08/16/02* (Date (Month/Day/Year))

(DO NOT DETACH)

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

This is to certify that Josepha Seletz (Full name of student.)

was granted the degree of Doctor of Medicine

by Temple University School of Medicine (Full name of School or College of Medicine as it appears on the Applicant's Medical degree diploma.) on May 27, 1976 (Date (Month/Day/Year))

that the date of his/her matriculation in medical school was September 11, 1972, and that he/she attended all reqd. (number) full courses of medical lectures comprising 9-12 (number) months. each for four years.

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

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

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

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

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

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

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

Signed: M. Judith Russo, M.D.

(Seal of College)

Dean
President
Secretary
Registrar

of Temple University School of Medicine Date: OCT 03 2002 (Month/Day), 20

Address: 3420 N. Broad Street, Philadelphia, PA 19140

10/2

University of California
San Francisco

UCSF

Dean's Office
San Francisco General Hospital

Dean's Office, Room 2A21
San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110
tel: 415/206-8505
fax: 415/285-2037

October 2, 2002

Arizona Board of Medical Examiners
9545 E. Doubletree Ranch Rd.
Scottsdale, AZ 85258

RE: Josepha Seletz, MD
558-88-9160

Arizona Board of Medical Examiners,

The office of the Associate Dean at San Francisco General Hospital verifys internships served at San Francisco General Hospital prior to 1980, when that internship program closed.

Regarding Dr. Josepha Seletz, we can find no record at this time of a rotating internship served by her in the late seventies.

Sincerely,

Bruce Tarver
Administrative Assistant

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
http://www.docboard.org/bp.nsx

Form 3
Postgraduate Training Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECT to the Arizona State Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258. Your prompt response will be appreciated.

Name: Joseph A Seletz, M.D.

See Application
Signature

08/16/02
Date (Month/Day/Year)

(DO NOT DETACH)

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

This is to certify that JOSEPH A SELETZ, M.D. undertook and satisfactorily completed a full term approved program of 36 (number) months in the KAISER HOSPITAL 4867 SUNSET BLVD (Full name and complete address of Hospital) LOS ANGELES CALIFORNIA 90027

in the field of OBSTETRICS AND GYNECOLOGY from 7-1-1977 (Date) (Mo/Day/Yr) to 6-30-1981 (Date/Anticipated Date)

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

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

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

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

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

The physical capability to perform medical tasks such as physical examination and surgical procedures, with 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, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? Yes [redacted] No [redacted] If yes, please attach written explanation.

[redacted] rated satisfactory and/or above? Yes X No

4. Were applicant's final evaluations in every [redacted] If no please attach written explanation.

Signed: Harry K. Gil, M.D.

Title: Residency Director

Address: 4900 Sunset Blvd Los Angeles Ca 90027 10-24-2002

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)

Endorsement of Certification

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 Telephone (215) 590-9392

RECEIVED SEP 07 2002

Recipient: Arizona Board of Medical Examiners
9545 E Doubletree Ranch Road
Scottsdale, AZ 85258

Date: 09/04/2002 **By:**

Examinee: Josepha Inez Seletz **Examinee ID:** 3-171-793-7 **Date of Birth:** [redacted]

NBME Certification Date: 07/01/1977 **Certificate#:** 171793

It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)	Individual Subject Scores: Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/11/1974	Pass	Three-Digit	500	(380)	605	530	530	415	475	455	475
		Two-Digit	80	(75)	87	83	83	75	79	78	79

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)	Individual Subject Scores: Med	Surg	ObGyn	Prev	Peds	Psych
09/23/1975	Pass	Three-Digit	465	(290)	415	445	565	560	375	480
		Two-Digit	80	(75)	78	79	85	85	76	81

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)
03/09/1977	Pass	Three-Digit	440	(290)
		Two-Digit	79.9	(75)

ARIZONA MEDICAL BOARD
2006 BIENNIAL MD LICENSE RENEWAL APPLICATION

2493

AZ MD Lic#: 31032 Josepha I. Seletz, MD — **Renewal Fee: $500 $850** (if postmarked after **10/26/2006**)

CURRENT INFORMATION Please review and make corrections as necessary ™	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER 10150 National Blvd Los Angeles CA 90034-3805	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**
Phone #: (310) 247-0553 **Fax #:**	**Phone #:** **Fax #:**
E-Mail: [redacted]	**E-Mail:**
MAILING ADDRESS 10150 National Blvd Los Angeles CA 90034-3805	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:**	**Phone #:** **Fax #:**
E-Mail:	**E-Mail:**
Mobile #:	**Mobile #:** (Optional)

RECEIVED BY:
OCT 10 2006
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

	Certified?	Practicing?		Certified?	Practicing?	Expiration Date	Initials Required
OBG	Y	Y	Make corrections if necessary INTIALS REQUIRED				

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

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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

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

CONTINUED ON BACK →

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

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

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

QUESTIONS CONTINUED ON NEXT PAGE →

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

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

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

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

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

Please note: All documents requested above must be sent directly from the primary source to the Arizona Medical Board's Physician Health Program Department from the primary source and will not be accepted if submitted by the applicant.
FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.
If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

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

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

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

I hereby certify, under penalty of perjury, I am a U.S. Citizen or a qualified/registered alien and that all information on this form is currently accurate. I also certify that during calendar years 2004 and 2005, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

Josepha Seletz 10/4/16

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

31032 Josepha I. Seletz, MD

ARIZONA MEDICAL BOARD
2004 BIENNIAL MD LICENSE RENEWAL APPLICATION

2014.

AZ MD Lic#: 31032 Josepha I. Seletz, MD **Renewal Fee: $500** **$850** (if postmarked after 10/26/2004)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 10150 National Blvd Los Angeles CA 90034-3805 **Phone #:** (310) 247-0553 **Fax #:** **E-Mail:** [redacted]	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** **Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS 10150 National Blvd Los Angeles CA 90034-3805	**MAILING ADDRESS**
HOME ADDRESS [redacted] **Phone #:** [redacted] **Fax #:** **E-Mail:**	**HOME ADDRESS** **Phone #:** **Fax #:** **E-Mail:** **Cell Phone #:** (Optional)

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

	Certified?	Practicing?
OBG	Y	N

Make corrections if necessary

	Certified?	Practicing?
OBG		Y

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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

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

PLEASE ANSWER THE FOLLOWING QUESTIONS:

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

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

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2002 and 2003, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

Josepha Seletz
Signature of Licensee (Signature stamp will not be accepted)

7-29-4
Date

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