49412 CASHIER'S CHECK 72355045 $50

ARIZONA MEDICAL BOARD
MD INITIAL LICENSE APPLICATION

9545 E Double Tree Ranch Rd., Scottsdale, AZ 85258
www.azmd.gov; Email: licensingreport@azmd.gov

RECEIVED APR 28 2014 AZ MEDICAL BOARD

To be completed and signed by applicant. All questions MUST be answered, even if only to indicate "None" or "N/A."

1. **First Name:** Kristin
   Middle Name: Jeanne
   Last Name: Livingston
   Other Names Used:
2. **Social Security Number:** [redacted] *No dashes*
3. **Date of Birth:** [redacted]
4. **City of Birth:** [redacted] **State of Birth:** [redacted]
   OR **Country of Birth:** [redacted]

Social Security Number, Date of Birth and Place of Birth are Confidential Information - Not for Public Disclosure

ADDRESSES:

Practice Address: This is the practice/principal place of business. The address and phone number will appear in the Medical Directory and on the Board's web site. Every physician must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public. If you want your home address to be listed on your web site profile, please so indicate. Otherwise, no address will be be provided on the profile, but it will be provided to the public if requested.

Mailing Address: If no address is provided, all Board correspondence will be sent to the Practice Address.

Email: This address is optional. If you provide an email address, it will not be released to the public.

Home Address: You are required to provide a home address and telephone number. They will not be released to the public *unless* you fail to provide an Office Address.

5. **Practice/Training Name:** Desert Star Family Planning
   Practice/Training Address: 1526 W. Glendale Ave #109 **City:** Phoenix **State:** AZ **Zip:** 85021
   Practice Phone: (480)447-8857 **Practice Fax:** (480)718-8411

Mailing Address: **City:** **State:** **Zip:**

Email: [redacted]

Home Address: [redacted] **City:** [redacted] **State:** [redacted] **Zip:** [redacted]

Home Phone: [redacted] **Mobile Phone:** [redacted]

ENTERED

6. PROOF OF CITIZENSHIP: Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States. A.R.S. §41-1080 and A.A.C. R4-16-201(C)(1), require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona.

☒ **I am a U.S. Citizen or U.S. National.** (If this box is checked, please submit with your application a certified copy of your Birth Certificate or U.S. Passport.)*

☐ **I am NOT a U.S. Citizen or U.S. National.** (If this box is checked, please submit with your application a copy of your permanent resident card or Visa.)*

*See Evidence list for complete list of accepted documents available at www.azmd.gov.

7. All states or provinces in which you have applied for or have been granted a license or registration to practice medicine, including license number, date issued and current status of the license. If more than five, attach a separate listing. If a license is pending or was not issued, so state. If none, please indicate "Not Applicable."

	State Board:	License No.:	Date Issued	License Status:
a.	California	A119869	12/14/11	Active
b.				
c.				
d.				
e.				

8. Medical School Name: Drexel University College of Medicine

Medical School Location: Philadelphia, Pennsylvania **Graduation Date:** 05/21/2010

If you graduated from a medical school located outside the United States of America or Canada, please list below:

ECFMG No.: Certificate Date:

9. List chronologically, all internship, residency and fellowship training in the U.S. or Canada *(completed or not)*, or assistant professorship (or higher) at any programs attended, showing institution, address, type of program and dates. Attach a separate listing if needed.

a. Institution: Kaiser Permanente Los Angeles Medical Center City: Los Angeles State: CA
Type of Program: Internship Dates of Attendance: From: 7/1/2010 To: 6/30/2011

b. Institution: Kaiser Permanente Los Angeles Medical Center City: Los Angeles State: CA
Type of Program: Residency Dates of Attendance: From: 7/1/2011 To: 06/30/2014

c. Institution: City: State:
Type of Program: Dates of Attendance: From: To:

d. Institution: City: State:
Type of Program: Dates of Attendance: From: To:

QUESTIONNAIRE

1. Have you had any application for medical licensure denied or rejected by another state or province licensing board? ☐ Yes ☒ No

2. Have you had any disciplinary or rehabilitative action taken against you by another licensing board, including other health professions? ☐ Yes ☒ No

3. Have you had any disciplinary actions, restrictions or limitations taken against you while participating in any type of training program or by any health care provider? ☐ Yes ☒ No

4. Have you ever been found in violation of a statute, rule, or regulation of any domestic or foreign governmental agency? ☐ Yes ☒ No

5. Have you been under investigation by any medical board or peer review body? ☐ Yes ☒ No

6. Have you ever 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? ☐ Yes ☒ No

7. Have your had hospital privileges revoked, denied, suspended, or restricted? ☐ Yes ☒ No

8. Have you been named as a defendant in a malpractice matter currently pending or that resulted in a settlement or judgment against you? If so, provide an explanation and a copy of the complaint and either the agreed terms of settlement or the judgment. The verification must contain the name and address of each defendant, the name and address of each plaintiff, the date and location of the occurrence which created the claim and a statement specifying the nature of the occurrence resulting in the medical malpractice action. ☐ Yes ☒ No

9. Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, sanction, or removal from practice, imposed by an agency of the federal or state government? ☐ Yes ☒ No

10. Have you had the authority to describe, dispense or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency? ☐ Yes ☒ No

11. Have you been found guilty or entered into a plea of no contest to a felony, misdemeanor involving moral turpitude in any state? (See list of explanations on web site at www.azmd.gov/Misdemeanors/Misdem.aspx) ☐ Yes ☒ No

12. Do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication? [redacted]

NOTE: In the event that the response to any of the questions above is "Yes," you must file an explanation.

Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

CONFIDENTIAL QUESTIONS

1. 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? [redacted]

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

NOTE: In the event that the response to any of the questions above is "Yes," you must file an explanation.

Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

First Name: Kristin **Last Name:** Livingston

10. License Exam. Please indicate all exams taken, the date(s) taken (month/day/year) and which state, if applicable:

☐ United States Medical Licensing Exam (USMLE): Step 3 Date: _____ State: CA

☐ State Written Examination: Date: _____ State: _____ *The Commonwealth of Puerto Rico is not accepted.*

☐ National Board of Medical Examiners Examination (NBME): Certification Date: _____

☐ Federation of State Medical Boards Licensing Examination (FLEX): Date: _____

☐ Licentiate of the Medical Council of Canada (LMCC): Date: _____

☐ Special Purpose Examination (SPEX): Date: _____ State: _____

11. Indicate your area of interest and whether you are certified by the American Board of Medical Specialties (ABMS):

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
Obstetrics and Gynecology	☐ Yes ☒ No	☒ Yes ☐ No	Board Eligible Date 6/30/14
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

Please Note: The Arizona Medical Board accepts Federation Credentials Verification Service (FCVS) documents that are received by the Board directly from the Federation of State Medical Boards (FSMB) as verification. Contact the Federation at http://www.fsmb.org if you need more information regarding this service.

☒ Check this box if you are using FCVS (Federation Credentials Verification Service)

Application Instructions

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

1. Certified evidence of legal name change if name is different from that shown on documents submitted with the application.
2. Citizenship Status form. The Citizenship status form applies to both U.S.A. Citizens and Non-Citizens alike.
3. A payment of $500 for processing your application. Should your application be approved you will be charged an additional fee which is a prorated licensing fee **of up to an additional $500** to cover your license through the time of renewal.

Application Checklist

The APPLICANT must forward the following enclosed forms to the appropriate entity for completion. **(If applicable)**
(Once completed by the entity, these forms are to be sent directly to the AMB.)

- ☐ Medical College Certification sent for
- ☐ Postgraduate Training Certification Sent for
- ☐ ~~Clinical Instructor Certification~~ N/A
- ☐ ~~ECFMG Certification~~ N/A
- ☐ Federation of State Medical Boards Disciplinary Search sent for
- ☐ American Medical Association Physician Profile sent for
- ☐ Verification of American Board or Medical Specialty Certification, if applicable N/A
- ☐ Examination Results
  USMLE, FLEX, SPEX, NBME or any State exam Sent for
- ☐ ~~Licentiate of the Medical Council of Canada (LMCC)~~ N/A
- ☐ Verification of Licensure from every state in which you have ever held a medical license or registration CA ⇒ sent for
- ☐ ~~Verification of all medical employment for the past five years. This must be submitted by the verifying entity on its official letterhead.~~ N/A
- ☐ ~~Verification of Hospital Affiliations for the past five years. This must be submitted by the verifying entity on its official letterhead.~~ N/A

NOTE: Arizona law requires an applicant who has been charged with a felony or a misdemeanor involving conduct that may affect patient safety after submitting the application to notify the Board within 10 days after the charge is filed. A.R.S. §32-3208. For a list of reportable misdemeanors, see the website under Physician Center - Reportable Misdemeanors. All felonies are reportable.

In addition to your e-mail address provided on page one of this application please indicate if you would like to designate/ authorize ONE other individual beside yourself to receive status updates on your application:

Name [redacted] Phone# [redacted] E-mail [redacted]

SUPPLEMENTAL FORM

Please list all hospital affiliations within the past five (5) years, including moonlighting and courtesy staff affiliations. ***Do not*** include postgraduate training or self employment. List all medical employment within the past five (5) years, i.e. medical clinic, physician placement group, emergency medical group, radiology group, etc.

☒ **Check here if you have not been employed or held hospital affiliations within the past 5 years**

☐ **Check here if you have been self employed for the past 5 years**

First Name: Kristin **Last Name:** Livingston

HOSPITAL/CLINIC AFFILIATION

a. Hospital/Clinic Name: From: To:

Address: City: State: Zip:

Position Held:

b. Hospital/Clinic Name: From: To:

Address: City: State: Zip:

Position Held:

c. Hospital/Clinic Name: From: To:

Address: City: State: Zip:

Position Held:

MEDICAL EMPLOYMENT

a. Employer Name: From: To:

Address: City: State: Zip:

b. Employer Name: From: To:

Address: City: State: Zip:

c. Employer Name: From: To:

Address: City: State: Zip:

ATTESTATION:

I attest that all of the information contained in the application and accompanying evidence or other credentials submitted are true. I attest the credentials submitted with the application were procured without fraud or misrepresentation or any mistake of which I am aware, and that I am the lawful holder of the credentials. I authorize the release of any information from any source requested by the Board necessary for initial and continued licensure in this state.

Signature of Applicant: Kristin J. Livingston, MD Date: 4/19/14

Notarization

Before me, _____ on this day personally appeared _____, known to me (or proved to me on the oath of _____ or through (description of identity card or other document)) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 20___.

(KG)

_____
Notary Public's Signature

(Personalized Seal)

State of California
County of Los Angeles
On 4/19/14 before me, Kevin Gutierrez Notary Public,
personally appeared Kristin Jeanne Livingston

who proved to me on basis to satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies) and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

KEVIN GUTIERREZ
Commission # 1949154
Notary Public - California
Los Angeles County
My Comm. Expires Sep 18, 2015

ARIZONA MEDICAL BOARD
Medical College Certification

I, Kristin Livingston request that my medical college certification or official transcript be submitted directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: Kristin L. Livingston, MD Date: 4/19/14

Requested from Drexel online

State of California
County of Los Angeles
On _____ before me, _____ Notary Public,
personally appeared _____

who proved to me on basis to satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies) and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

ARIZONA MEDICAL BOARD
AMERICAN MEDICAL ASSOCIATION PHYSICIAN PROFILE

REQUEST FOR AMERICAN MEDICAL ASSOCIATION (AMA) PHYSICIAN PROFILE
Profiles will be sent directly to the ARIZONA MEDICAL BOARD, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258,
or email: licensingreport@azmd.gov.

To request a copy of your AMA Profile, please contact:

American Medical Association
515 North State Street
Chicago, IL 60610

or you can order your AMA Profile online at www.ama-assn.org/amaprofiles

I, Kristin Livingston request that my AMA profile be submitted directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: Kristin Livingston, MD Date: 4/19/14

Requested online

ARIZONA MEDICAL BOARD
AMERICAN BOARD OF MEDICAL SPECIALTIES CERTIFICATION

REQUEST FOR AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) CERTIFICATION
Verifications will be sent directly to the ARIZONA MEDICAL BOARD, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258, or email: licensingreport@azmd.gov.

If you are board certified you must request a copy of your ABMS Certification.

American Board of
Medical Specialties
1007 Church Street, Suite 404
Evanston, Illinois 60201

N/A, not yet board-certified

or you can order your ABMS Certification online at www.abms.org

I, _____, request that my ABMS certification be submitted directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: _____ Date: _____

ARIZONA MEDICAL BOARD
STATE LICENSE VERIFICATION

I, Kristin Livingston request that my state license verification be submitted directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: Kristin J. Livingston, MD Date: 4-19-14

Letter sent to CA Med Board on 4-23-14

ARIZONA MEDICAL BOARD
MEDICAL EMPLOYMENT VERIFICATION REQUEST

Note: Verification is required from the employer where the applicant has been employed during the five years preceding the application.

I, _____, request that verification of my medical employment be submitted on the **letterhead** of the **verifying Employer** directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: _____ Date: _____

N/A, currently completing residency

ARIZONA MEDICAL BOARD
FEDERATION OF STATE MEDICAL BOARDS REPORT

REQUEST FOR FEDERATION OF STATE MEDICAL BOARDS (FSMB) REPORT
Reports will be sent directly to the ARIZONA MEDICAL BOARD, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258,
or email: licensingreport@azmd.gov.

To request a copy of your FSMB report, please contact:

FSMB Offices
400 Fuller Wiser Road, Suite 300
Euless, TX 76039

or you can order your FSMB Report online at www.fsmb.org
(Physician Data; Overview; FPDC; Board Action Inquiry Request Form)

I, _____, request that my FSMB report be submitted directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: Kristi L. Linnert, MD Date: 4-19-14

ordered online through FSMB.org

ARIZONA MEDICAL BOARD
ECFMG CERTIFICATION

REQUEST FOR STATUS REPORT FOR ECFMG CERTIFICATION
Certifications will be sent directly to the ARIZONA MEDICAL BOARD, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258, or email: licensingreport@azmd.gov.

To confirm ECFMG certification status for an international medical graduate, please contact:

ECFMG Certification Verification Service
PO Box 48083
Newark, NJ 07101-4883
or you can order your ECFMG certificate online at www.ecfmg.org

I, _____, request that my ECFMG certification be submitted directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: | Date:

N/A

ARIZONA MEDICAL BOARD
LICENTIATE OF THE MEDICAL COUNCIL OF CANADA

LICENTIATE OF THE MEDICAL COUNCIL OF CANADA (LMCC)
Verifications will be sent directly to the ARIZONA MEDICAL BOARD, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258, or email: licensingreport@azmd.gov.

To request a copy of your LMCC verification, please contact:

Medical Council of Canada
P.O. Box 8234 Stn T
Ottawa, ON Canada K1G 3H7

or online at http://www.mcc.ca/en/

I, _____, request that my LMCC verification be submitted directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: _____ Date: _____

N/A

ARIZONA MEDICAL BOARD
EXAMINATION RESULTS

REQUEST FOR EXAMINATION RESULTS

I, Kristin Livingston, request that my examination results be submitted directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: Kristin L Livingston, MD Date: 4-19-14

☒ USMLE
☐ FLEX, SPEX

United States Medical Licensing
3750 Market Street
Philadelphia, PA 19104

Requested online

www.usmle.org

Federation of State Medical Boards
(817) 868-5178

www.fsmb.org/transcripts.html

☐ NBME

National Board of Medical Examiners
www.nbme.org

☐ State Exam

Contact the appropriate state board

ARIZONA MEDICAL BOARD
HOSPITAL AFFILIATION VERIFICATION REQUEST

Note: Verification is required from the hospital where the applicant has held privileges, consultation or teaching appointments during the five years preceding the application.

I, _____, request that verification of my hospital affiliation be submitted on the **letterhead** of the **verifying hospital** directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: _____ Date: _____

N/A, currently completing residency

US·MLE
United States
Medical
Licensing
Examination

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4000

Date : 04/16/2014

Recipient:

Arizona Medical Board
ATTN: C. Lloyd Vest, II, JD, Exec Director
9545 E Doubletree Ranch Road
Scottsdale, AZ 85258

Examinee: Livingston, Kristin Jeanne
Alt Name(s):

Examinee ID#: 5-211-795-9
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	06/12/2008	Pass	248	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	07/01/2009	Pass	235	(184)	

Clinical Skills (CS)*

	Test Date	Pass/Fail	Total	MP	Comments
	05/05/2009	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
CALIFORNIA	06/23/2011	Pass	223	(187)	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Examinee ID#: 5-211-795-9

Examinee: Livingston, Kristin Jeanne **Date of Birth:** [redacted]

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. **No score is reported.** Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information.* Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note. 4/2013

AMB - Physician Renewal - Confirmation (Step 8 of 11)

7/28/2015

Dr. Kristin Jeanne Livingston

Please review the information below and click at the bottom to accept. If you need to correct the information, click the links below the records.

General Questions

Note: ***In the event the response to any of the questions numbered 1 through 10 is â€œYESâ€***, you must file by fax or mail a detailed report concerning the below 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.

1) Since 2009, have you had an application for medical licensure denied or rejected by another state or province licensing board? If so, provide an explanation.

No

2) Since 2009, has any disciplinary or rehabilitative action been taken against you by another licensing board, including other health professions? If so, provide an explanation.

No

3) Since 2009, have any disciplinary actions, restrictions or limitations taken against you while participating in any type of program or by any health care provider? If so, provide an explanation.

No

4) Since 2009, 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? If so, provide an explanation.

No

5) Since 2009, have you had hospital privileges revoked, denied, suspended, or restricted? If so, provide an explanation.

No

6) Since 2009, 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? If so, provide an explanation.

No

7) Since 2009, have you had your authority to prescribe, dispense, or administer medications limited, restricted,

modified, denied, surrendered, or revoked by a federal or state agency? If so, provide an explanation.

No

8) Since 2009, have you engaged or do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication? If so, provide an explanation.

[redacted]

9) Since 2009, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? Is so, provide an explanation. See list of Moral Turpitude items at .

No

10) Since 2009, have you failed the special purpose licensing examination (SPEX)?

No

Physical/Mental Health and Substance Abuse Questions

In the event you answer YES to any of the below questions, you must file with the application a detailed written narrative statement concerning the above matter(s), including the name of healthcare providers and treatment centers where you were treated, along with the discharge summary of your treatment and progress. If you are currently participating or have participated in the past 5 years pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of physician assistantâ€™s impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with a compliance reports from the state monitoring programs

FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.

1) Since 2009, have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine including diagnosis or treatment for any psychotic disorder or substance abuse disorder? If so, provide an explanation.

[redacted]

2) Since 2009, have you consumed intoxicating beverages resulting in your ability being impaired or limited to exercise the judgment and skills of a medical professional? If so, provide an explanation

[redacted]

Citizenship Status

I am a U.S. Citizen or U.S. National

Specialties

	Specialty	Certified?	Practicing?	Date Certified	Expiration Date
Primary Specialty	Obstetrics & Gynecology		Yes		
Specialty 2					
Specialty 3					
Specialty 4					

Practice Address

Glendale Ob/gyn
5750 W. Thunderbird Rd. Suite D400
Glendale AZ, 85306
Phone: (602) 298-8977
Fax: (602) 298-1787

You are required to enter a valid address, if you have one.

Home Address

[redacted]

You are required to enter a valid address, if you have one.

Mailing Address

Rosy Santamaria
5750 W. Thunderbird Rd. Suite D400
Glendale AZ, 85306
[redacted]

You are required to enter a valid address, if you have one.

Please review all information you have provided. Change any information given or click on the I Agree button to verify that all information posted above is correct and to proceed to payment options.

By agreeing with this data, you are signing this registration form and certifying under pentalty of perjury 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 the two calendar years preceding renewal year as required by A.R.S. Â§32-1434 and A.A.C. Â§ 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. Â§32-3211.

I Agree **Yes** **No**

MD Training Unit

Complete

You may wish to print this Page for your records.

After pressing the ***Next*** button, please be patient, as it may take a few moments to process your data and send you to the payment page.