RECEIVED
MAR 01 2012
AZ MEDICAL BOARD

ARIZONA MEDICAL BOARD
MD INITIAL LICENSE APPLICATION

9545 E Double Tree Ranch Rd., Scottsdale, AZ 85258
Phone: 480-551-2700 Fax: 480-551-2707

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

1. **First Name:** Laura **Middle Name:** Terese **Last Name:** Mercer

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:**

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:** Banner Good Samaritan Medical Center

Practice/Training Address: 1111 E McDowell Rd **City:** Phoenix **State:** AZ **Zip:** 85006

Practice Phone: +1 (602) 839-3827 **Practice Fax:** +1 (602) 839-5112

Mailing Address: 1111 E McDowell Rd **City:** Phoenix **State:** AZ **Zip:** 85006

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. Federal law, 8 U.S.C. §1641 and State law, A.R.S. §1-501, 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 copy of your Birth Certificate, U.S. Passport, or Naturalization Certificate.)*

☐ **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 Statement of Citizenship form for complete list of accepted documents available on the website.

7. **All states or provinces in which you *have or had* a license or registration. 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."**

a. State Board: _____ License No.: _____ License Status: N/A

b. State Board: _____ License No.: _____ License Status: _____

c. State Board: _____ License No.: _____ License Status: _____

d. State Board: _____ License No.: _____ License Status: _____

e. State Board: _____ License No.: _____ License Status: _____

8. **Medical School Name:** University of Arizona College of Medicine

Medical School Location: Tucson, Arizona **Graduation Date:** Jan 1, 2009

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: Banner Good Samaritan Medical Center City: Phoenix State: AZ

Type of Program: Residency Dates of Attendance: From: Jan 1, 2009 To: current

b. Institution: _____ City: _____ State: _____

Type of Program: _____ Dates of Attendance: From: _____ To: _____

c. Institution: _____ City: _____ State: _____

Type of Program: _____ Dates of Attendance: From: _____ To: _____

d. Institution: _____ City: _____ State: _____

Type of Program: _____ Dates of Attendance: From: _____ To: _____

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: Feb 24, 2010 State: Arizona

☐ 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 & Gynecology	☐ Yes ☒ No	☒ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

12. Have you been in medical practice continuously for the past 10 years (or since graduation from medical school)? (If you mark "No," please submit a narrative explaining any lapses in practice (i.e. preparing for USMLE, sabbatical, etc.)

☒ Yes ☐ No

Explanation:

QUESTIONNAIRE

1. Have you had any application for any professional license refused or denied by any licensing authority? ☐ Yes ☒ No

2. Have you been refused or denied the privilege of taking an examination required for any professional licensure? ☐ Yes ☒ No

3. Have you been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled? ☐ Yes ☒ No

4. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently? ☐ Yes ☒ No

5. Have you voluntarily surrendered any healthcare license? ☐ Yes ☒ No

6. Have you had any healthcare license revoked? ☐ Yes ☒ No

7. 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, license healthcare facility or healthcare staff of such facility? ☐ Yes ☒ No

8. 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

9. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? "Disciplinary Action" includes, but is not limited to restriction, termination, voluntary or involuntary resignation or withdrawn. ☐ Yes ☒ No

10. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility? ☐ Yes ☒ No

11. 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

12. Have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, or misdemeanor involving moral turpitude? (See explanation below) *A "yes" answer is required even if you entered a diversion program.* ☐ Yes ☒ No

13. Have you been charged with or convicted (including a nolo contendre plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not the sentence was imposed or suspended? ☐ Yes ☒ No

14. In the last ten (10) years, has a judgment or settlement been entered against you as a defendent in a medical malpractice suit? *Please do not report pending malpractice suits or settlements paid not related to a civil action* ☐ Yes ☒ No

15. Have you been court martialed or discharged other than honorably from the armed service? ☐ Yes ☒ No

16. Have you been terminated from a healthcare position with a city, county, or state government or the Federal government? ☐ Yes ☒ No

17. Have you ever 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 that the response to any of the questions above is "Yes," you must 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 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 Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and 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.

First Name: Laura **Last Name:** Mercer

CONFIDENTIAL QUESTIONNAIRE

[redacted]

1. 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?

2. Are you now being treated or have you in the last five years been treated 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?

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.

NOTE: In the event that the response to any of the questions above is "Yes," 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 doctors of medicine impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with compliance reports from the state monitoring programs.

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

RELEASE OF RECORDS:

I 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 Medical Board 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 Medical Board or its successors to release to the organizations, individuals or groups listed above any information which is material to the application or any subsequent license.

ATTESTATION:

I ATTEST THAT ALL INFORMATION SUBMITTED ON AND WITH THIS APPLICATION IS TRUE. I am the person herein named subscribing to this application; I have read the statutes and rules regarding licensure and have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. I am 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 I am aware. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the application or to hold a hearing to revoke the license, if issued.

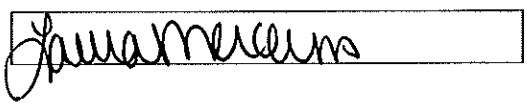
NOTE: Arizona law requires an applicant who has been charged with a felony or a misdemeanor involving conduct that may affect patient safety after submitting the application to notify the Board within 10 days after the charge is filed. A.R.S. §32-3208. For a list of reportable misdemeanors, see the website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

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

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 _____ Phone# _____ E-mail _____

First Name: Laura **Last Name:** Mercer

Signature:  **Date:** 24 Feb 2012

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, 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: Laura **Last Name:** Mercer

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:

Mercer

USMLE
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) 868-4041

Date : 02/27/2012

Recipient:

Arizona Medical Board
ATTN: Lisa S Wynn, Executive Director
9545 E Doubletree Ranch Road
Scottsdale, AZ 85258

Examinee: Mercer, Laura
Alt Name(s): Mercer, Laura Terese

Examinee ID#: 5-196-881-6
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, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/13/2007	Pass	228	185	95	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	09/23/2008	Pass	243	184	99	75	

Clinical Skills (CS)*

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	02/23/2009	Pass					

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
ARIZONA	08/02/2010	Pass	216	187	91	75	

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

ARIZONA MEDICAL BOARD
POSTGRADUATE TRAINING VERIFICATION FORM

AUTHORIZATION: The Arizona Medical Board requires all applicants for licensure to obtain verification of all postgraduate training programs attended. This form must be completed by the **Program Director.** This is authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board. Authorization may be sent via mail or fax to 9545 E Doubletree Ranch Road, Scottsdale, AZ 85258 or (480) 551-2704.

First Name: LAURA **Last Name:** MERCER

Signature: Laura Mercer **Date:** 24 Feb 2012

Important - Program Participation: Report incomplete postgraduate years (PGY) separately from those that were successfully completed. If the postgraduate year is currently in progress, report the **expected completion date in the "To" field.** Report internships, residencies and fellowships separately.

PG Year: 1 **Department/Specialty:** Obstetrics & gynecology

- [x] Internship
- [ ] Residency
- [ ] Fellowship

From: 6/23/09 To: 6/30/10 (mm/dd/yy)

Successfully Completed? [ ] Yes [ ] No [ ] In Progress

PG Year: 2 **Department/Specialty:** Obstetrics & gynecology

- [ ] Internship
- [x] Residency
- [ ] Fellowship

From: 7/1/10 To: 6/30/11 (mm/dd/yy)

Successfully Completed? [x] Yes [ ] No [ ] In Progress

PG Year: 3 **Department/Specialty:** Obstetrics & gynecology

- [ ] Internship
- [x] Residency
- [ ] Fellowship

From: 7/1/11 To: 6/30/12 (mm/dd/yy)

Successfully Completed? [ ] Yes [ ] No [x] In Progress

Affix Training Program Seal Here

This program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Examination Education (ACGME), or the Royal College of Physicians and Surgeons of Canada: [x] Yes [ ] No

Institution Name: Banner Good Samaritan Medical Center **Name/Title:** John H. Watt Fox MD Chair and Program Director

Address: 1111 East McDowell Road **City:** Phoenix **State:** AZ **Zip:** 85006

Phone: 602-839-4344 **Fax:** 602 839-2359 **Signature:** John H. Watt Fox MD

Date: 2/29/12 (mm/dd/yy)

Ck#2097190
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MAY 24 2010
AZ MEDICAL BOARD

ARIZONA MEDICAL BOARD
POSTGRADUATE TRAINING PERMIT REGISTRATION
(Internship-Residency-Fellowship)

The Board shall grant a one year renewable training permit to a person participating in a teaching hospital's accredited internship, residency or clinical fellowship training program to allow that person to function only in the supervised setting of that program. If a person who is participating in a teaching hospital's accredited internship, residency or clinical fellowship program must repeat or make up time in the program due to resident progression or other issues, the Board may grant that person a training permit if requested to do so by the program's director of medical education or a person who holds an equivalent position. The individual must register with the Board for each year of training and pay the statutory nonrefundable **$50.00** registration fee.

The following information must be completed by the applicant and the licensed hospital which sponsors the accredited training program. This form also applies to applicants applying for a short-term training permit of four months or less. Please submit the registration to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, AZ 85258 at least **thirty days prior** to the initiation of the training.

☒ (Check this box if this is a renewal for a current Postgraduate Training Permit)

Permit # R 71519 Expiration Date 6/30/10

1. Applicant Name: Mercer (Last) Laura (First) Terese (Middle)
2. Current home address: [redacted] (Number and Street) (City) (State) (Zip)
3. Mobile Phone Number: _____ Home Phone Number: [redacted]
4. E-Mail address: [redacted]
5. Date of Birth: [redacted] (Month, Day and Year) [redacted] (City, State and Country of Birth)
6. Social Security Number: [redacted]

PROGRAM TO COMPLETE BELOW:

Type of Program: Internship ☐ Residency ☒ Fellowship ☐

Name of Facility: Banner Good Samaritan Medical Center
(Arizona ACGME Approved Hospital or University Name)

Specialty Field: Obstetrics and Gynecology
(i.e. Internal Medicine, Gastroenterology, Psychiatry, Family Medicine, etc….)

Permit Dates requested from: 7/1/10 (mm/dd/yy) to 6/30/11 (mm/dd/yy) (not to exceed one year)

I hereby certify I am authorized to request a postgraduate training permit for the above named facility.

Signature: Alan I Leibowitz Title: Chief Academic Officer

Name Printed: Alan I. Leibowitz, MD

Date: 5/10/10 Phone Number: 602-839-2296

Arizona Medical Board: Permit Issued: Date: _____ Permit Number: _____

ENTERED

Rec'd 179405Y

ARIZONA MEDICAL BOARD

POSTGRADUATE TRAINING PERMIT APPLICATION

(Internship-Residency-Fellowship)

The Board shall grant a one year renewable training permit to a person participating in a teaching hospital's accredited internship, residency or clinical fellowship training program to allow that person to function only in the supervised setting of that program. If a person who is participating in a teaching hospital's accredited internship, residency or clinical fellowship program must repeat or make up time in the program due to resident progression or other issues, the Board may grant that person a training permit if requested to do so by the program's director of medical education or a person who holds an equivalent position. The individual must register with the Board for each year of training and pay the statutory nonrefundable **$50.00** registration fee.

The following information must be completed by the applicant and the licensed hospital which sponsors the accredited training program. If the applicant is applying for a short-term training permit of four months or less please also complete the Receiving Hospital Information. Please submit the application to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, AZ 85258 at least **thirty days prior** to the initiation of the training.

1. Applicant Name: Mercer (Last) Laura (First) Terese (Middle)
2. Current home address: [redacted] (Number and Street) (City) (State) (Zip)
3. Date of Birth: [redacted] (Month, Day and Year) [redacted] (City, State and Country of Birth)
4. Social Security Number: [redacted]
5. Medical School Name: University of Arizona College of Medicine
   Medical School Location: Tucson, Az Date of Graduation: May 15, 2009 (Month/Day/Year)
6. If you graduated from a medical school located outside the United States of America or Canada please list below:
   ECFMG # _____ Certificate Date: _____ (Month/Day/Year)
7. All States or provinces in which you have or had a license or registration. If more than two, attach separate listing. If license is pending or was not issued, so state. If none, please indicate by stating "Not Applicable."

(a) _____
(State Board) (License No.) (Status of License, i.e., expired, active, etc.)

(b) _____
(State Board) (License No.) (Status of License, i.e., expired, active, etc.)

8. List chronologically, all Internship, Residency and Fellowship training in 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 separate listing if needed.

INSTITUTION NAME	CITY/STATE	TYPE OF PROGRAM/PGY YEAR	DATES OF ATTENDANCE

9. Account for, in **chronological order**, all activities since graduation from medical school to present. ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.

10. Have you ever had any application for any professional license refused or denied by any licensing authority?	YES ☐	NO ☒
11. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐	NO ☒
12. Have you ever been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled?	YES ☐	NO ☒
13. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently?	YES ☐	NO ☒
14. Have you ever voluntarily surrendered any healthcare license?	YES ☐	NO ☒
15. Have you ever had any healthcare license revoked?	YES ☐	NO ☒
16. Have you ever 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 ☒
17. Have your privileges ever 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 ☒
18. 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 ☒
19. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☒
20. Have you ever 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 ☒
21. Have you ever 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 ☒
22. Have you ever 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 ☒
23. In the last ten (10) years has a judgment or settlement been entered against you as a defendant in a medical malpractice suit? ***Please <u>do not</u> report <u>pending</u> malpractice suits or <u>settlements paid not related to a civil action.</u>**	YES ☐	NO ☒
24. Have you ever been court martialed or discharged other than honorably from the armed service?	YES ☐	NO ☒
25. Have you ever been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐	NO ☒
26. Have you ever 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: ***<u>In the event the response to any of the questions numbered 10 through 26 is "YES"</u>*****, the applicant must 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). IN ADDITION, the applicant must submit photocopies of any complaints, hearings, settlements or judgments together with copies of patient's hospital and/or office records to the AMB.**

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.

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

1. 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]
2. Are you now or have you in the last 5 years been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?	
3. Are you now being treated or have you in the last 5 years 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. Have you ever 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 application a detailed written narrative statement concerning the above matter(s), including the name and address of all training programs or 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 AMB.**

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, INCLUDING REVOCATION OR DENIAL OF A PERMIT.

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.

The applicant Laura Terese Mercer

(PRINT OR TYPE YOUR NAME)

being first duly sworn upon his oath deposes and says: that I am the person herein named subscribing to this application; that I have read the statutes and rules regarding licensure and have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am 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 Medical Board 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 Medical Board 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.

Under penalty of perjury I certify:

☒ **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.)

Signature of Applicant Laura Mercer **, M.D.** **Date** 31 March 09

*** 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 AMB WITHIN 10 DAYS AFTER THE CHARGE IS FILED. ARIZONA REVISED STATUTE (A.R.S.) §32-3208 (SEE WEBSITE UNDER *Physician Center – Reportable Misdemeanors* FOR LIST OF REPORTABLE MISDEMEANORS – ALL FELONIES ARE REPORTABLE.)**

HOSPITAL CERTIFICATION

Type of Program: Internship X Residency □ Fellowship □

This is to certify that , **Laura Mercer,** M.D., is currently engaged in a hospital training program in the field of ___**Obstetrics and Gynecology**_ at (name of hospital) **Banner Good Samaritan Medical Center**.

The program COMMENCED on _June 23, 2009 and the anticipated date of completion is June 30, 2013.

This specific request for permit is for the dates of _**June 23, 2009**__ through __**June 30, 2010**____.

I certify that the program is accredited by the. ACGME, and certify that the answers to the following statements are true and correct: *If the answer to either question is YES, please attach a written explanation*

1. Have any actions, restrictions, limitations (including probation or academic probation) been taken while the applicant was participating in any training program? Yes† **No X**
2. Does the applicant have any disability which may affect his/her ability to safely engage in the practice of medicine? [redacted]

Signature Alan I. Leibowitz Title **Chief Academic Officer**

Name Printed: **Alan I. Leibowitz, MD**

SEAL OF HOSPITAL

Date: **May 8, 2009**

Should the postgraduate trainer be terminated from the program at any time, the facility must notify the Board immediately. Upon termination from the program, the postgraduate training permit bolder no longer has valid credentials and may no longer practice medicine in Arizona. Should the facility wish to allow the postgraduate trainer to rejoin the program, a new application must be filed.

RECEIVING HOSPITAL CERTIFICATION

The board shall grant a training permit to a person who is not licensed in this state and who is participating in a short-tenor training program of four months or less conducted in an approved school of medicine or a hospital that has an accredited hospital internship, residency or clinical fellowship program in this state for the purpose of continuing medical education.

RECEIVING HOSPITAL CERT IFICATION FOR ROTATION DOCTORS
FOUR MONTHS OR LESS

Name of receiving hospital: _____

Address of receiving hospital: _____

Name Signed: _____

Name Printed:

Date of Rotation: _____ Prom: _____ To: _____

(For Official Use Only)

Arizona Medical Board: Permit Issued Date 6/5/09 Permit Number R71519 Approved by JY

Arizona Medical Board

9545 E. Doubletree Ranch Road, Scottsdale AZ 85258 • website: www.azmd.gov
Phone (480) 551-2700 • Toll Free (877) 255-2212 • Fax (480) 551-2707

April 15, 2015

***** sent via email and US Mail***

Dr. Laura Terese Mercer
1661 E Camelback Road #160
Phoenix, AZ 85016

[redacted]

This will acknowledge receipt of your renewal application for licensure to practice medicine in the State of Arizona. At the time of renewal, all files are reviewed for completeness. If it is determined that anything is missing, it is requested at this time.

To complete the processing of your renewal application, the following documentation is still needed:

1.) **Please complete and submit ***all four pages*** of the Medical Practice Act Training unit (attached).**

*****Please do NOT fax photos; they do not come across clear. Scanned copies or pictures of the photo may be emailed or mailed*****

PLEASE NOTE: If the above items are not received within 60 days of this notice, your Arizona Medical License will expire on its scheduled expiration date. Any items that are received after the 60 day period will not be accepted. If your license expires you may reapply as an initial applicant.

Should you wish to appeal any item in this deficiency letter you must submit your request for a hearing to the Board pursuant to AAC R4-16-206(B)(2) within 30 days from the date of this notice.

A.R.S. § 32-1430:
B. A person renewing an active license to practice medicine in this state shall provide to the board as part of the renewal process a report of disciplinary actions, restrictions or any other action placed on or against that person's license or practice by another state licensing or disciplinary board or an agency of the federal government. This action may include denying a license or failing the special purpose licensing examination. The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action taken.
C. The licensee shall submit proof with the renewal form of having completed a training unit as prescribed by the board relating to the requirements of this chapter and board rules.
D. A person whose license has expired may reapply for a license to practice medicine as provided in this chapter.

R4-16-207. Time-frames for License Renewal; Expiration

B. For license renewal, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is 45 days and begins on the date the Board receives the renewal application.
1. If the required application is not administratively complete, the Board shall send a written deficiency notice to the applicant.
a. In a deficiency notice, the Board shall state each deficiency and the information required to complete the application or supporting documentation.
b. Within 60 days after the Board sends a deficiency notice, the applicant shall submit to the Board the requested documentation or information specified in the notice. The time-frame for the Board to finish the administrative completeness review is suspended from the date of the notice until the date the Board receives the requested documentation or information from the applicant.
D. If a person holding an active license does not apply for license renewal according to the biennial renewal requirement or fails to meet time-frame requirements under this Section, the person's license expires according to provisions prescribed under A.R.S § 32-1430(A) unless the person is under investigation according to provisions prescribed under A.R.S. § 32-3202.

Kendra Drake
Arizona Medical Board
Licensing Assistant
Kendra.Drake@azmd.gov

CL 46314

ARIZONA MEDICAL BOARD
Biennial MD LICENSE RENEWAL APPLICATION

9545 E Doubletree Ranch Road, Scottsdale, AZ 85258
www.azmd.gov; eMail: licensingreport@azmd.gov

RECEIVED
MAR 23 2015
ARIZONA MEDICAL BOARD

☒ **License Fee $500** (if postmarked by due date)

☐ **License Fee $850** (if postmarked after due date)

BEFORE COMPLETING THIS RENEWAL FORM: Please review your physician profile, located at www.azmd.gov. If any of the information is incorrect, please print a copy, line out the erroneous information, write in the correct information and submit it with your renewal. You are subject to discipline if you provide erroneous information. Please note that name changes must be made under separate cover.

NOTE: Effective February 14, 2012, the Arizona Medical Board (AMB) no longer issues **wallet cards**. A physician's AMB website profile is the most reliable way to verify current license status. The profile can be accessed at **www.azmd.gov**

First Name: Laura **Initial:** T **Last Name:** Mercer

License Number: 46121

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.

Practice/Training Name: Arizona Ob/gyn Affiliates, MOGA

Practice/Training Address: 1001 E Camelback Rd #100 **City:** Phoenix **State:** AZ **Zip:** 85016

Practice Phone: 602-241-1071 **Practice Fax:** 602-230-7982

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

☒ Same as Practice Address ☐ Same as Home Address

Email: [redacted]

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

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

ENTERED

AMERICAN BOARD OF MEDICAL SPECIALTY (ABMS) CERTIFICATIONS AND FIELDS OF PRACTICE: Please review and correct the fields of practice and ABMS board certification information as shown on your profile. Only certifications from the American Board of Medical Specialties will be shown. Select the fields of practice form the drop down list. If you are Board certified, check "yes".

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
ob/gyn	☐ Yes ☒ No	☒ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

PROOF OF CITIZENSHIP: 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.

However, if you provided documentation to the Board of your U.S. citizenship or nationalization at the time of your last renewal or at the time of your initial application to the Board, no further documents are required.

Alternatively, if you have become a U.S. citizen or U.S. national since the time of your most recent application with the Board or are not currently a U.S. citizen or national, you must submit proof of your current status to the Board before your license will be renewed.

Documentation can be submitted to the Board via email at Licensingreport@azmd.gov. Please see the Evidence List on the Board's website (www.azmd.gov) for a list of acceptable documents. Additionally, a certified copy of the birth certificate or certified copy of the passport must be submitted in accordance with R4-16-201(C)(1) if you have not previously established your citizenship or nationalization with the Board.

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

☐ **I have become a U.S. Citizen or U.S. National since the time of my last renewal.**

☐ **I am NOT a U.S. Citizen or U.S. National.**

PROTOCOL FOR STORAGE, TRANSFER AND ACCESS OF PATIENT MEDICAL RECORDS

☒ I am aware that it is unprofessional conduct to fail to have a written protocol in place for the secure storage, transfer and access of patient medical records when a physician terminates or sells his/her practice and the medical records do not remain in the same physical location. I have a 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 exempt from the records protocol requirement as outlined in A.R.S. 32-3211(G). I am a health professional who is employed by a health care institution as defined in Section A.R.S. 36-401 that is responsible for the maintenance of the medical records.

☐ I have no patient records that I am required to maintain under A.R.S. Section 12-2297 or any other statute or federal law.

Note: ARS Section 12-2297 requires the maintenance of a patient's medical records as follows: 1. If the patient is an adult, for at least six years after the last date the adult patient received medical or health care services from that provider. 2. If the patient is a child, either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services form that provider, whichever date occurs later. 3. Source data may be maintained separately from the medical record and must be retained for six years from the date of collection of the source data.

CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

☒ I have completed a minimum of 40 hours CME during the two previous calendar years of renewal year as required by A.R.S. §32-1434 and A.A.C. §R4-16-101.

**** Please do not submit proof of CME unless you received notice on your renewal that you are subject to a CME audit.*
If an audit was indicated, submit the CME documentation with your completed renewal.

First Name: Laura **Last Name:** Mercer **License Number:** 46121

REQUEST FOR CHANGE IN LICENSE STATUS: You may request INACTIVATION or CANCELLATION of your license using this form. Do not submit a license renewal fee if you are requesting inactivation or cancellation, however; you must sign and date this form.

☐ **I request INACTIVATION of my medical license.** I am not presently under investigation by the Board, the Board has not commenced 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 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, the Board may require me to pass the SPEX and any combination of physical, psychiatric, or psychological examinations or interviews it deems necessary to determine my ability to safely engage in the practice of medicine. A.R.S. §32-1431.

☐ **I request CANCELLATION of my medical license**. I am not presently under investigation by the Board, the Board has not commenced disciplinary proceedings against me, and I am no longer practicing medicine in Arizona.

QUESTIONNAIRE

1. Since 2009, have you had any application for medical licensure denied or rejected by another state or province licensing board? If so provide an explanation.	☐ Yes	☒ 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.	☐ Yes	☒ No
3. Since 2009, have any disciplinary actions, restrictions or limitations been taken against you while participating in any type of program or by any healthcare provider? If so, provide an explanation.	☐ Yes	☒ 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.	☐ Yes	☒ No
5. Since 2009, have you had hospital privileges revoked, denied, suspended, or restricted? If so, provide an explanation.	☐ Yes	☒ 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.	☐ Yes	☒ 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.	☐ Yes	☒ 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 a misdemeanor involving moral turpitude in any state? If so, provide an explanation. See list of Moral Turpitude items at www.azmd.gov.	☐ Yes	☒ No
10. Since 2009, have you failed the special purpose licensing examination (SPEX)?	☐ Yes	☒ No

NOTE: In the event that the response to any of the questions above 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.

ARS 32-1430(B): A person renewing an active license to practice medicine in this state shall attach to the completed renewal form a report of disciplinary actions, restrictions or any other action placed on or against that person's license or practice by another state licensing or disciplinary board or an agency of the federal government. This action may include denying a license or failing the special purpose licensing examination. The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action taken.

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 Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and 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.

First Name: Laura **Last Name:** Mercer **License Number:** 46121

CONFIDENTIAL QUESTIONS

1. Since 2009, 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? 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.	

NOTE: In the event that the response to any of the questions above is "Yes," 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 doctors of medicine impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/ order along with compliance reports from the state monitoring programs.

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

ATTESTATION:

I ATTEST THAT ALL INFORMATION SUBMITTED ON AND WITH THIS RENEWAL APPLICATION IS TRUE. This includes information and responses provided on all four pages of the renewal application, any corrections made to the enclosed physician profile, and any information provided on or submitted with the CME Audit Form.

First Name: Laura **Initial:** T **Last Name:** Mercer

License Number: 46121

Signature of Applicant: Laura Mercer Date: 3/19/15

Questions?

Arizona Medical Board: License Renewal Questions

Laura Mercer 2013 License # 46121 Professional Conduct

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	**No**	
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	**No**	
3. Since your last renewal have you voluntarily surrendered any healthcare license?	**No**	
4. Since your last renewal have you had any healthcare license revoked?	**No**	
5. Since your last renewal have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**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?	**No**	
7. Since your last renewal, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? -Disciplinary Action- includes, but is not limited to, restriction, termination, voluntary or involuntary resignation or withdrawn.	**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?	**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.	**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?	**No**	
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	**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?	**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?	**No**	

Arizona Medical Board: License Renewal Questions

Laura	Mercer	2013	License # 46121	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.