MD PROFILE PAGE

Arizona Medical Board

azmd.gov
Printed on 06/13/16 @ 07:48

General Information

Barbara Ellen Zipkin MD
Camelback Family Planning
4141 W.32nd St.
Phoenix AZ 85018
Phone: (602) 279-2337

License Number: 26425
License Status: Active
Licensed Date: 05/08/1998
License Renewed: 04/07/2015
Due to Renew By: 04/09/2017
If not Renewed, License Expires: 08/09/2017

Education and Training

Medical School:	NWU, FEINBERG SCH OF MED Chicago, Illinois
Graduation Date:	12/19/1975
Residency:	07/01/1976 - 07/01/1980 (Obstetrics & Gynecology) NORTH SHORE UNIVERSITY HOSPITAL MANHASSET, NY
Area of Interest	Obstetrics & Gynecology

The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

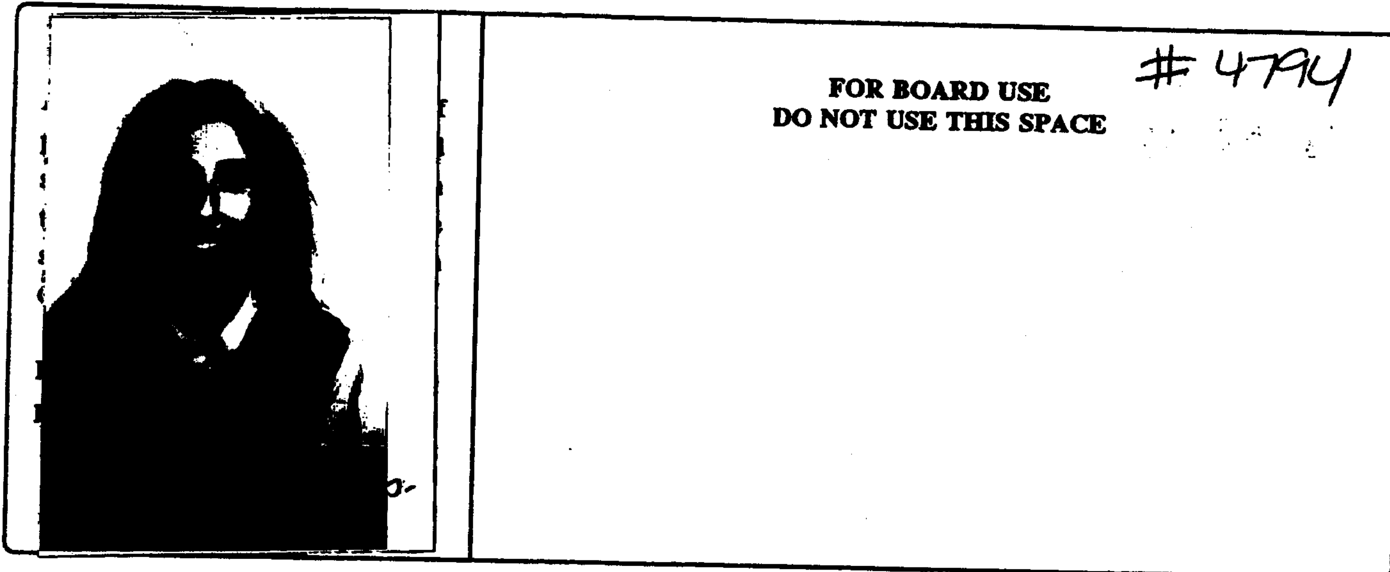
Board Actions

None

ARIZONA BOARD OF MEDICAL EXAMINERS

1651 E. Morten Avenue, Suite 210
Phoenix, Arizona 85020
A.C. (602) 255-3751

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE THROUGH ENDORSEMENT



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

INFORMATION

All candidates shall provide satisfactory evidence that he/she:

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

NOTE: Applications are processed on a first-come first-served basis; the processing of a routine application can take 10 to 12 weeks. Applications not fully complete within one year from date of receipt are considered withdrawn.

APPLICATION INSTRUCTIONS
(Read Carefully)

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

1. Evidence of name and date of birth: a photocopy of birth certificate; documentary evidence for consideration etc. (Visa, Passport; or alien resident card.)
2. Certified evidence of any legal name changes other than that shown on certificates filed in accordance with paragraph 1 above, (e.g., marriage certificate). Proof of foreign birth of American parents.
3. Photocopy of M.D. Degree Diploma; OR M.B., B.S. Degree Diploma for foreign graduates.
4. Photocopy of the DD 214 Form of release from U.S. military or public health service. OR if currently serving, have attached herewith a letter from any Commanding Officer setting forth the dates of active duty, assignments, and anticipated date of release from active duty.
5. Photocopies of any certificates awarded by any of the American medical specialty boards.
6. Photocopies of all certificates awarded upon completion of any internship, residency, fellowship or other post-graduate medical education undertaken in United States or Canadian hospitals; OR letters of certification of partial; past; or current training.
7. The names and addresses of all your hospital affiliations for the five years prior to filing this application and the Chief of Staff or Chief of Service for each.
8. A statement of your exact whereabouts and nature of practice or other activities from the date of graduation from medical school to the present, with specific MONTH AND YEAR listed for each. NO PERIOD UNACCOUNTED FOR IS ALLOWED.

9. Cashier's Check or Money Order in U.S. Funds (personal checks not accepted), covering the statutory fee of $450.00. There are no refunds.
10. Applicants, whose written examination; FLEX examination; National Board of Medical Examiners (NBME) or Licensing Medical Council of Canada (LMCC) certificates, upon which endorsement is sought was received more than ten years preceding the filing of this application, are required to submit to the Special Purpose Examination (SPEX).
11. Credentials submitted in foreign languages shall have affixed thereto a certified translation into English.
12. Separated or Mutilated Applications are not acceptable and will require refiling.
13. Requests for exemptions or waivers of any portion of this application will be denied and will delay your consideration for licensure.
14. **NOTE:** All credentials submitted must remain the property of the Arizona Board of Medical Examiners and NONE will be returned.
15. Photocopies shall not exceed 8½ inches by 11 inches in size.

UNITED STATES OR CANADIAN MEDICAL SCHOOL GRADUATES

Graduates of medical schools located in the United States or Canada which were approved by the Council on Medical Education of the American Medical Association, the Canadian Medical Council, or the Association of American Medical Colleges, will forward forms numbered I, II, and III to the appropriate agency with the request that they be completed and returned directly to the Arizona Board of Medical Examiners.

ALL OTHER MEDICAL SCHOOL GRADUATES

Graduates of medical schools located outside the United States or Canada will forward Forms numbered I, II, III, III-A, and IV as may be applicable, to the appropriate agency with the request that they be completed and returned to the Arizona Board of Medical Examiners.

Note: Applications will not be processed nor considered until ALL required forms are completed and returned directly to the Arizona address provided.

APPLICATION

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

1. Present Legal Name: Zipkin, Barbara Ellen
   PRINT OR TYPE (Last) (First) (Middle) (Maiden)
   (a) Other names used: ✓
2. Office Address: [redacted]
   (No.) (Street) (City) (State) (Zip Code) (Phone)
3. City and State of Birth [redacted] Month, Day and Year of Birth [redacted]
4. In what states or provinces have you applied for or been granted license or registration? If more than two, attach separate listing. If license not issued, so state.

   (a) California — (State Board) — (Date of Application) — 1/3/77 (Result) — G-41246 (Certificate No.)
   1/3/77 (Date Issued) — (Specify if by Written Examination or on Credentials)

   (b) N.Y. — (State Board) — (Date of Application) — 7/1/77 (Result) — 131,258 (Certificate No.)
   7/1/77 (Date Issued) — (Specify if by Written Examination or on Credentials)

5. Has any disciplinary or rehabilitative action including reprimand, censure, probation, restriction, limitation, suspension, stipulation, written consent agreement or revocation ever been taken against you by any state licensing (including other health professions) Board? no (ANSWER)
6. Have any actions, restrictions, limitations (including probation or academic probation) been taken while you were participating in any type of training program or by any health care provider? no (ANSWER)
7. Have you ever been charged with a violation of any statute, rule or regulation of any domestic or foreign governmental agency? no (ANSWER)
8. Has there been any action initiated against you by or through any medical board or association? no (ANSWER)

9. Have you ever had a medical license revoked; suspended; limited; restricted; placed on probation; voluntarily surrendered or canceled during an investigation or in lieu of disciplinary action, entered into a consent agreement or stipulation? no (ANSWER)

10. Have you ever had hospital privileges revoked; denied; suspended or restricted in any way? no (ANSWER)

11. Have you ever been named as a defendant in any malpractice matter which resulted in a settlement or judgement against you in excess of $20,000? no (ANSWER)

12. Have you ever been convicted of Medicare of Medicaid fraud or received sanctions (including restriction, suspension or removal from practice) imposed by any agency of the federal government? no (ANSWER)

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

Note: In the event the response to any of the questions numbered 5 through 13 is YES, the applicant will file with the application a detailed report concerning the above matters; including, any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the results of any hearings, and the disposition of such charge(s). Provide the name and address of applicant's insurance carrier and the name and address of patient's attorney. IN ADDITION, the applicant must provide that certified photocopy(ies) of any hearings, settlements or judgements, together with copies of patient's hospital and/or office records, be submitted to this Board.

14. Have you ever taken a leave of absence (other than for pregnancy) during medical school, training, or any other practice? If yes, please attach a written explanation. no (ANSWER)

15. Do you have any chronic ailment communicable to others?

16. Do you have any medical condition which in any way impairs or limits your ability to safely practice any field of medicine? (ANSWER)

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

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

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

17. Within the last ten years, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? (ANSWER)

Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? (ANSWER)

If you answered "YES" to any part of this question, please provide details on a Supplemental Form, including date(s) of diagnosis or treatment, a description of the course of treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment.

18. List Internships, Residency and Fellowship training; OR, Assistant Professorship (or higher) at approved school of medicine chronologically showing institution, address, type of program and dates. Attach separate listing if needed.

OB-Gyn Internship - North Shore Univ. Hosp. 7/1/76 - 6/30/77
OB-Gyn Residency - North Shore Univ. Hosp. 7/1/77 - 6/30/80

19. Are you certified by an American Board medical specialties? yes Specialty OB-Gyn

20. Have you completed the educational requirements for any of the American Board of medical specialties? If so, which? Ø

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

At L.A., Calif. (City) (State) from 8/1/80 to present

At Manhasset, N.Y. (City) (State) from 7/1/76 to 6/30/80

At ______ (City) (State) from ______ to ______

At ______________________ (City) (State) ______ from ______ to ______

At ______________________ (City) (State) ______ from ______ to ______

At ______________________ (City) (State) ______ from ______ to ______

22. In the event you are successful in obtaining a license to practice medicine by this application, have you selected a location?
No Where? ______

Solo or in Association with? ø

23. What is your intended specialty practice? OB-Gyn

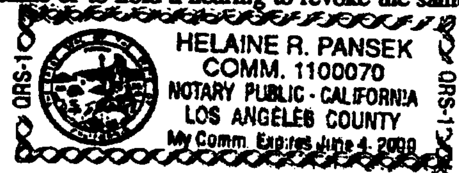
24. What branch of the United States Armed Forces have you served with, if any, including USPHS? ø

Active duty? From ______ (Month and Year) to ______ (Month and Year)

The applicant Barbara Zigtin, M.D. (PRINT OF TYPE) (Name in Full)

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

Signature of Applicant ______________________, M.D.



(NOTARIAL SEAL)

STATE OF California
County of Los Angeles } ss

Subscribed and sworn to before me this ______ day of ______ 19 ______

Notary Signature ______ (NOTARY PUBLIC) My Commission expires ______

FOR OFFICE USE ONLY

Application Rec'd 3/11 19 98		Application Processed by [illegible]
Application Completed ______ 19 ______		Application Checked by bd
Form No. I Rec'd 3/25 19 98		Application Approved April 27 19 98
Form No. II Rec'd 3/20 19 98		By Becky Drew
Form No. III Rec'd 3/23 19 98		License Issued May 7 19 98
Form No. III Rec'd ______ 19 ______		License No. 26425
Form No. III-A Rec'd ______ 19 ______		
Form No. IV Rec'd ______ 19 ______		
Investigation Completed ______ 19 ______		
Application withdrawn ______ (Date)		

Revised 3/97 IPS 40221

Barbara Zipkin,M.D.

March 6, 1998

Arizona Board of Medical Examiners
1651 E. Morten Ave., Ste. 210
Phoenix, Az. 85020

Dear Sirs,

In regards to the information needed concerning my whereabouts since medical school, I was engaged in a residency program at North Shore University Hospital, Manhasset, N.Y., from July 1,1976 until June 30, 1980. I was trained in the practice of Obstetrics and Gynecology and became Board certified. From August 1, 1980, until the present time, I am engaged in a full time practice of Obstetrics and Gynecology . My office address is and has been 4900 Sunset Boulevard, Los Angeles, California, 90028.

I am currently affiliated with Kaiser Permanente Hospital, 4867 Sunset Blvd., L.A., Ca., 90028, and have been since 8/1/80. The Chief of Service is Dr. F. Nevarez, 4900 Sunset Blvd., L.A., Ca. My practice consists of a general Ob-Gyn practice, with unrestricted privileges. A letter from Dr. Nevarez will be forthcoming.

If any further information is needed, please let me know and I will be happy to provide it. Thank you for your assistance.

Sincerely,

Barbara Zipkin, M.D.

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American Board of Obstetrics & Gynecology

Robert C. Cefalo, M.D., Ph.D.
Chapel Hill, NC
President

Mary J. O'Sullivan, M.D.
Miami, FL
Vice President

Morton A. Stenchever, M.D.
Seattle, WA
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Chicago, IL
Chairman of the Board

William Droegemueller, M.D.
Chapel Hill, NC
Director of Evaluation

Norman F. Gant, M.D.
Executive Director
2915 Vine Street
Dallas, TX 75204-1069
Phone: (214) 871-1619
Fax: (214) 871-1943

Eli Y. Adashi, M.D.
Baltimore, MD

Alan H. DeCherney, M.D.
Boston, MA

Philip J. DiSaia, M.D.
Orange, CA

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Denver, CO

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Oklahoma City, OK

Edward E. Wallach, M.D.
Baltimore, MD

Gerson Weiss, M.D.
Newark, NJ
Directors

Incorporated 1930

A founding member of
The American Board of
Medical Specialties

March 9, 1998

Credentialing Department
Board of Medical Examiners of Arizona
1651 E. Morten Avenue, Suite 210
Phoenix, AZ 85020

Reference: **Barbara Zipkin, M.D.**
SS [redacted]
Diplomate #20356

Dear Administrator:

The above referenced physician is a **diplomate** of the American Board of Obstetrics & Gynecology, Inc. (ABOG) certified in 1983.

This office responds to inquiries concerning the status of physicians in the certification process according to the following:

1. An individual is a registered residency graduate with ABOG when, upon application, ABOG rules that he/she has fulfilled the requirements to take the written examination.

2. An individual achieves active candidate status by passing the written examination. This status is limited to six years or three attempts to pass the oral examination. If active status has expired, it may be regained by retaking and passing ABOG's written examination.

3. An individual becomes a **diplomate** of ABOG when he/she has fulfilled all requirements, has satisfactorily completed the written and oral examinations and has been awarded ABOG's certifying diploma. Diplomas issued in 1986 for basic Ob/Gyn and in November 1987 for subspecialties, as well as all subsequent dates are valid for a maximum of 10 years.

Sincerely yours,

N Gant MD

Norman F. Gant, M.D.
Executive Director

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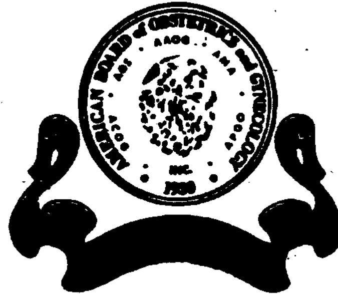
American Board of Obstetrics and Gynecology



COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY-OBSTETRICS
CERTIFIES THAT

BARBARA ELLEN ZIPKIN

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC. SHE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT SHE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HER PROFICIENCY IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED AND SHE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD

DECEMBER 9, 1983

PRESIDENT

SECRETARY

Charles B. Hammond, M.D.

THE AMERICAN COLLEGE
OF
OBSTETRICIANS AND GYNECOLOGISTS

CERTIFIES THAT

BARBARA ELLEN ZIPKIN

HAVING FULFILLED THE REQUIREMENTS
HAS BEEN ELECTED A **FELLOW** OF THIS COLLEGE
WHICH IS DEDICATED TO THE MAINTENANCE OF THE HIGHEST STANDARDS
IN PATIENT CARE, MEDICAL EDUCATION AND RESEARCH IN OBSTETRICS AND GYNECOLOGY

SEPTEMBER 30, 1984

Luella Klein M.D.
PRESIDENT

SECRETARY

FORM I

MEDICAL COLLEGE CERTIFICATION

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the medical school granting the medical degree. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 1651 EAST MORTEN AVENUE, SUITE 210, PHOENIX, ARIZONA 85020. Your early response will be appreciated.

Name: Barbara Zipkin, M.D. (Please Print or Type) _______________, M.D. (Signature)

Date: 3/1/98

(DO NOT DETACH)

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

This is to certify that Barbara Zipkin (Full Name of Student)

whose photograph is attached hereto, was granted the degree of Doctor of Medicine by

Northwestern University Medical School on December 19 19 75,
(Full Name of School or College of Medicine as it appears on the Applicant's Medical degree diploma)

that the date of his/her matriculation in medical school was October 02, 1972; and that he/she attended

12 Qtr (Number) full courses of medical lectures comprising Three (Number) months each as verified be the attached certified copy of his/her transcripts.

1. Was applicant ever required to repeat any segment of training? No If YES, which part(s)? _______________
2. Was applicant ever placed on probation, restricted or limited? No If YES, please attach a written explanation.
3. Was there any reason not to continue applicant in the training program? No If YES, please attach a written explanation.
4. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

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

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

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

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

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

5. Was the applicant ever diagnosed with or treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? [redacted]

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Has the applicant ever been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? [redacted]

If "YES" to any part of this question, please provide details on a Supplemental Form.

6. Did applicant ever take a leave of absence (other than for pregnancy) during medical school, training or any other practice? No If YES, please attach a written explanation.

7. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed [signature] ~~M.D.~~

Dean / President / Secretary (circled) / Registrar } of Northwestern University Medical School

(SEAL OF COLLEGE)

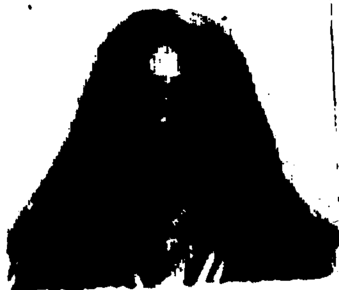
Date March 23, 1998

Address: 303 E. Chicago Ave., Chicago, IL 60611

Please return completed form DIRECT to:
Arizona Board of Medical Examiners, 1651 E. Morten Avenue, Suite #210, Phoenix, Arizona 85020

Revised 2/95 Reorder # IPS 40168

The applicant must assume the responsibility for completion of this form and is forewarned that it must be fully completed and forwarded to the Arizona Board of Medical Examiners before any application may be considered.



Northwestern University

ON RECOMMENDATION OF THE FACULTY OF THE

SCHOOL OF MEDICINE

NORTHWESTERN UNIVERSITY HAS CONFERRED THE DEGREE OF

DOCTOR OF MEDICINE

UPON

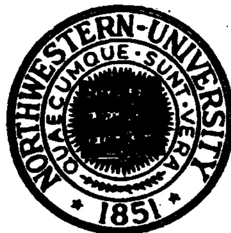
BARBARA ELLEN ZIPKIN

WHO HAS HONORABLY FULFILLED ALL THE REQUIREMENTS PRESCRIBED BY THE UNIVERSITY FOR THAT DEGREE

DONE AT EVANSTON ILLINOIS THIS NINETEENTH DAY OF DECEMBER IN THE YEAR OF OUR LORD ONE THOUSAND NINE HUNDRED AND SEVENTY-FIVE

Thomas G. Ayers
CHAIRMAN OF THE BOARD OF TRUSTEES

C. A. McCormick
SECRETARY OF THE BOARD OF TRUSTEES



Robert H. Strotz
PRESIDENT OF THE UNIVERSITY

James E. Eckenhoff, M.D.
DEAN

FORM III

POSTGRADUATE TRAINING CERTIFICATION

TO WHOM IT MAY CONCERN:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved post-graduate training program in the United States or Canada. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 1651 EAST MORTEN AVENUE, SUITE 210, PHOENIX, ARIZONA 85020. Your early response will be appreciated.

Name: Barbara Zipkin, M.D. (Please Print or Type) [signature], M.D. (Signature)

Date: 3/1/98

(DO NOT DETACH)

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

This is to certify that Barbara Zipkin (Name of Applicant in Full), M.D. undertook and satisfactorily completed a full term approved program of Residency (Number) months in the: North Shore University Hospital (Full Name and Complete Address of Hospital) 300 Community Drive, Manhasset, NY 11030

in the field of Obstetrics and Gynecology from 7/76 (Date) to 8/80 (Date/Anticipated Date)

and that the said program was approved for post-graduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. YES X NO ____

1. Was applicant ever required to repeat any segment of training? NO If YES, which part(s)?
2. Was applicant ever placed on probation, restricted or limited? NO If YES, please attach a written explanation.
3. Was there any reason not to continue applicant in the training program? NO If YES, please attach a written explanation.
4. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

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

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

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

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"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes,

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mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

5. Was the applicant ever diagnosed with or treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? [redacted]

Has the applicant ever been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? [redacted]

If "YES" to any part of this question, please provide details on a Supplemental Form.

6. Did applicant ever take a leave of absence (other than for pregnancy) during medical school, training or any other practice? NO If YES, please attach a written explanation.

7. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed [signature]

Title Program Director

Address: 300 Community Drive

(SEAL OF HOSPITAL)
(So indicate if none)

Date 3-11-98, 19

Revised 2/95 Reorder # IPS 40160

> The applicant must assume the responsibility for completion of this form and is forewarned that it must be fully completed and forwarded to the Arizona Board of Medical Examiners before any application may be considered.

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MAR 23 98

NORTH SHORE HEALTH SYSTEM

NORTH SHORE UNIVERSITY HOSPITAL

300 COMMUNITY DRIVE, MANHASSET, NEW YORK 11030 • (516) 562-4435

Department of Obstetrics and Gynecology

S. THEODORE HORWITZ, M.D.
Associate Chairman

Professor of Clinical
Obstetrics and Gynecology

March 10, 1998

Arizona Board of Medical Examiners
1651 East Morten, Ste 210
Phoenix, AZ 85020

RE: Dr. Barbara Zipkin

To Whom It May Concern:

This letter is to confirm that Dr. Barbara Zipkin has completed her residency in the Department of Obstetrics and Gynecology at North Shore University Hospital (July 1, 1976 through June 30, 1980)

If you should have any additional questions please feel free to contact my office.

Sincerely,

S. T. Horwitz

S.Theodore Horwitz, MD
Residency Program Director
Department of OB/GYN

STH:*crm*

RECEIVED B.O.M.E.X.
MAR 23 98

THE BOARD OF TRUSTEES OF

North Shore University Hospital

MANHASSET, LONG ISLAND, NEW YORK

hereby certifies that

Barbara Ellen Zipkin, M.D.

has served as

Resident Obstetrician/Gynecologist I, II, III

July 1, 1976 to June 30, 1979

and during that time discharged the duties of the office with ability and integrity

IN WITNESS WHEREOF *we have affixed the Seal of the Hospital on*

June 30, 1980

Department Director

Chairman, Medical Board

Executive Vice President for Administration

Associate Dean, Cornell University Medical College

President

THE BOARD OF TRUSTEES OF

North Shore University Hospital

MANHASSET, LONG ISLAND, NEW YORK

hereby certifies that

Barbara Ellen Zipkin, M. D.

has served as

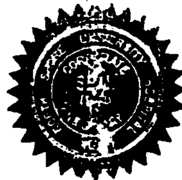
Chief Resident Obstetrician/Gynecologist IV

July 1, 1979 to June 30, 1980

and during that time discharged the duties of the office with ability and integrity

IN WITNESS WHEREOF *we have affixed the Seal of the Hospital on*

June 30, 1980



Department Director

Chairman, Medical Board

Executive Vice President for Administration

Associate Dean, Cornell University Medical College

President

RECEIVED B.O.M.E.X.

NATIONAL BOARD OF MEDICAL EXAMINERS®

Record of Scores and Endorsement of Certification

This document was prepared by
National Board of Medical Examiners (NBME)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

Recipient: Arizona State Bd Med Exam
1651 E Morten Avenue
Suite 210
Phoenix, AZ 85020

Date: 03/13/1998

Examinee ID: 3-165-118-5

Examinee: Barbara Ellen Zipkin

Date of Birth: [redacted]

NBME Certification Date: 01/03/1977

Certificate#: 165118

This record shows only NBME passing scores for each NBME examination reported on this document unless a complete NBME examination history has been requested by the examinee. If applicable, also results for USMLE Steps taken by this examinee (and for which scores have been reported to date) are shown.

This examinee has successfully completed the examination, education and training requirements for NBME certification.

NBME PART I

			Total		Individual Subject Scores						
Test Date	Pass/Fail	Score Scale	Score	(Min. Pass)	Anat	Phys	Bioc	Path	Micr	Phar	Beh Scr
09/1974	Pass	Three-Digit	420	(380)	465	415	435	390	475	440	390
		Two-Digit	76	(75)	78	75	76	75	79	77	75

NBME PART II

			Total		Individual Subject Scores					
Test Date	Pass/Fail	Score Scale	Score	(Min. Pass)	Med	Surg	ObGyn	PM/PH	Peds	Psych
04/1975	Pass	Three-Digit	400	(290)	385	310	390	415	480	530
		Two-Digit	78	(75)	76	73	77	78	81	84

NBME PART III

			Total	
Test Date	Pass/Fail	Score Scale	Score	(Min. Pass)
05/1976	Pass	Three-Digit	440	(290)
		Two-Digit	79.9	(75)

*** **END OF DOCUMENT** ***

See reverse side for explanation of information reported above.

RECEIVED B.O.M.E.X.
MAR 20 98 AZ 1060

Authenticity of NBME Record of Scores

Original, certified copies of the NBME Record of Scores are printed on green safety paper and are produced only by the NBME. The embossed NBME seal in the lower left corner certifies the authenticity of this document. Alteration or forgery of the NBME Record of Scores may result in appropriate legal action or other action consistent with NBME or USMLE policies.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

NBME Part I and Part II Examinations June 1991 and Thereafter

The most recent total test score is reported. This score is on a scale with a mean of 200 and a standard deviation of 20, in increments of 1. Most scores fall between 150 and 250.

All NBME Part III Examinations

The most recent total test score is reported. This score is on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

Two-Digit NBME Scores

For all NBME scores, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

USMLE Step 1, Step 2 and Step 3

Reports of scores on USMLE include a complete score history, and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For recent administrations, the mean and standard deviation of scores on the three-digit scale for first-time examinees from medical schools in the United States are approximately 205 and 20, respectively, and most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 82 on the two-digit scale is equivalent to a score of 200 on the three-digit scale. A score of 75 on the two-digit scale is always the minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each Step of USMLE is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 6 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Special circumstances in connection with the administration of USMLE may result in one of the following annotations being listed next to the score for that examination:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

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

Irregular Behavior - The USMLE Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information.* To obtain information regarding the nature of the irregular behavior, the full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9600.

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.

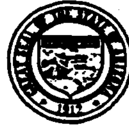
Testing Accommodations - Following review and approval of a request from the examinee, testing accommodations were provided in the administration of the examination.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA
SATISFACTION OF REQUIREMENTS SUMMARY

Applicant:	Zipkin, Barbara Ellen
Birthplace:	[redacted] Date [redacted]
Medical Education	From Northwestern University Medical Center in Chicago, Illinois **Degree Date:** 12/19/1975
Postgraduate Training	**In:** Obstetrics & Gynecology **for** 48 **months at** NORTH SHORE UNIVERSITY HOSPITAL **From** 07/01/1976 **to** 07/01/1980
Clinical	
Boards	**Of** Obstetrics & Gynecology 12/9/83 — Educational Requirements Met / Is a diplomate
Written Examinations	
Endorsement	National Board Part III **taken on** 01/03/77 **in** in a single sitting with a score of 79
SPEX	
Licenses	AMA; 4/6/98, N/D FSMB; 3/20/98, N/D California; 4/1/98, current, N/D New York; 3/24/98, non renewed, N/D
	B bd 4/17/98 4/27/98

Jane Dee Hull
Governor

Claudia Foutz
Executive Director
Tom Adams
Assistant Director, Regulation
Donna Linkous
Assistant Director, Operations



Arizona State Board of Medical Examiners

1651 East Morten, Suite 210 • Phoenix, Arizona 85020
Home Page: http://www.docboard.org/bomex

Ram R. Krishna, M.D.
Chairman

William J. Waldo, M.D.
Vice Chairman

Tim B. Hunter, M.D.
Secretary

Telephone (602) 255-3751 • Fax (602) 255-1848 • In-State Toll Free (877) 255-2212

CERTIFIED MAIL RETURN RECEIPT REQUESTED

May 18, 1999

RE: Arizona Medical License

Dear Doctor:

Please find enclosed your Arizona license, replacing your previously issued Limited License, in accordance with your request and the passage of Senate Bill 1091.

If you have questions, please contact me at (602) 255-3751, extension 7103.

Sincerely,

Marie Slaughter

Marie Slaughter
Assistant Licensing Manager

Is your RETURN ADDRESS completed on the reverse side?

SENDER:
- Complete items 1 and/or 2 for additional services.
- Complete items 3, 4a, and 4b.
- Print your name and address on the reverse of this form so that we can return this card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit.
- Write *"Return Receipt Requested"* on the mailpiece below the article number.
- The Return Receipt will show to whom the article was delivered and the date delivered.

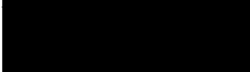
I also wish to receive the following services (for an extra fee):

1. ☐ Addressee's Address
2. ☐ Restricted Delivery

Consult postmaster for fee.

3. Article Addressed to:

Barbara Ellen Zipkin, M.D.



4a. Article Number

Z 469 233 299

4b. Service Type

☐ Registered ☒ Certified
☐ Express Mail ☐ Insured
☐ Return Receipt for Merchandise ☐ COD

7. Date of Delivery

5-27

5. Received By: *(Print Name)*

6. Signature: *(Addressee or Agent)*

X [signature]

8. Addressee's Address *(Only if requested and fee is paid)*

PS Form 3811, December 1994 102595-98-B-0229 Domestic Return Receipt

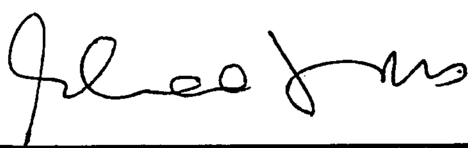
Thank you for using Return Receipt Service.

REQUEST TO CONVERT LIMITED LICENSE TO UNRESTRICTED MEDICAL LICENSE

RECEIVED B.O.M.E.X.
MAY 10 99

I, **Barbara Ellen Zipkin, M.D.** request that the Arizona Board of Medical Examiners convert my "Limited License" to practice medicine in my designated medical specialty to an unrestricted license to practice medicine.

5/5/99



Date | Signature

NOTICE OF REFUSAL TO REQUEST UNRESTRICTED MEDICAL LICENSE

I, **Barbara Ellen Zipkin, M.D.** decline to request an unrestricted Board license. I understand that, as a result of my decision to refuse conversion of my limited license to an active unrestricted Board license, the Board may institute formal administrative proceedings to rescind, revoke or void any limited license for 1998 or 1999 previously issued by the Board to me, if I do not voluntarily surrender limited licensure.

Date | Signature

INSTRUCTIONS: Mail or deliver this form, after reading and signing, to **Arizona State Board of Medical Examiners - Attention: Licensing Section, 1651 E. Morten, Suite 210, Phoenix, Arizona 85020**

Jane Dee Hull
Governor

Claudia Foutz
Executive Director

Arizona State Board of Medical Examiners
1651 East Morten, Suite 210 Phoenix, Arizona 85020
Phone (602) 255-3751 Fax (602) 255-1848
Home Page: http://www.docboard.org

Ram R. Krishna, M.D.
Chairman

William J. Waldo, M.D.
Vice Chairman

Tim B. Hunter, M.D.
Secretary

May 3, 1999

Barbara Ellen Zipkin, M.D.

Re: Physicians Holding Limited License to Practice Medicine; Statutory Revision of Board Authority

Dear Dr. Zipkin:

On April 26, 1999, Governor Jane Dee Hull signed Senate Bill (S.B.) 1091 into law and it became effective immediately. S.B. 1091 in part authorizes the Board to convert Board licenses of physicians, that were previously held or received in calendar year 1998, and that restricted medical practice to a designated area of medical specialization (i.e., "limited licenses"), to active unrestricted Board licenses to practice medicine in the State of Arizona.

The Board's licensing records reflect that you held or were authorized by the Board to receive a limited license in 1998. Pursuant to S.B. 1091, before the Board may issue you a new unrestricted Board license, a request must be received by the Board from a qualified physician to convert the limited license to an unrestricted Board license.

If you wish to request unrestricted licensure to practice medicine in Arizona, sign the attached form where designated and return the form by mail or personal delivery to the Board's office. Upon receipt of your request, staff will promptly process your request for unrestricted active license. Please note that S.B. 1091 mandates that the request to convert to unrestricted Board license must be made within 120 days from the effective date of S.B. 1091, i.e., April 26, 1999.

If you are currently practicing medicine in Arizona, pursuant to 1998 or 1999 limited license, you should promptly submit your request to convert to an active unrestricted license to avoid any legal ambiguity over your ability to lawfully continue practicing medicine in the State of Arizona. Limited licenses to practice medicine, that are not converted to active unrestricted licenses, shall be subject to administrative action by the Board for revocation or nullification of those limited licenses, after expiration of the aforementioned 120 day time period. If you do not intend to convert your limited license to an unrestricted license, please sign, date and return the attached form as provided.

Thank you for your patience and cooperation while the Board and the Legislature resolved this difficult issue arising out of the expiration of the Board's previous statutory authority to issue limited licenses. Please call the Board if you have any questions at (602) 255-3751 ext. 7800.

Sincerely,

Claudia Foutz

Claudia Foutz, Executive Director

Enclosure

Jane Dee Hull
Governor

Claudia Foutz
Executive Director
Melissa S. Cornelius, JD
Deputy Director

Arizona State Board of Medical Examiners
1651 East Morten, Suite 210 Phoenix, Arizona 85020
Telephone (602) 255-3751 Fax (602) 255-1848
Home Page: http://www.docboard.org

Ram R. Krishna, M.D.
Chairman

William J. Waldo, M.D.
Vice Chairman

Tim B. Hunter, M.D.
Secretary

Certified Mail/Return Receipt Requested
No. Z434973287

January 27, 1999

Barbara Ellen Zipkin, M.D.

Re: Notice of Nullification of all 1999 Limited Licenses to Practice Medicine in Arizona issued by BOMEX

Dear Doctor Zipkin:

INTRODUCTION

This letter is sent to advise you of a significant change in the statute that previously authorized the State Board of Medical Examiners (hereafter, "BOMEX") to issue a special license to practice medicine which limited a physician to his or her certified area of medical specialty. See, Arizona Revised Statutes ("A.R.S") § 32-1426(C), as amended and effective in 1995 until expiration on November 1, 1998. BOMEX physician licensure records reflect that you were sent a 1999 license that limited your right to practice medicine in Arizona solely for your certified area of medical specialization.[1]

Effective as of November 1, 1998, and pursuant to amendment of state statute A.R.S. § 32-1426(C), BOMEX's authority to issue licenses to physicians that limit the practice of medicine in Arizona to a certified medical specialty expired. Additionally, the statute did not authorize existing BOMEX physicians, with limited licenses to practice a medical specialty (referred to hereafter as "limited licenses"), to be "grandfathered" or converted to regular unrestricted BOMEX physician licensure. Therefore, BOMEX may not legally renew any pre-existing limited medical practice license for 1999 or issue new limited licenses to new applicants for 1999. An agency of the State may only exercise that authority and power as provided by Arizona Constitution or statute. BOMEX may only

[1] If this is not a correct statement of your licensure status with BOMEX, please promptly send a letter, to the address appearing at the end of this letter advising this agency of what you believe is your correct licensure status and enclose a photocopy of last BOMEX license identity card received by you.

Is your RETURN ADDRESS completed on the reverse side?

SENDER:
- Complete items 1 and/or 2 for additional services.
- Complete items 3, 4a, and 4b.
- Print your name and address on the reverse of this form so that we can return this card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit.
- Write "Return Receipt Requested" on the mailpiece below the article number.
- The Return Receipt will show to whom the article was delivered and the date delivered.

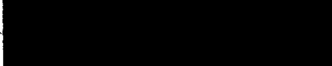
I also wish to receive the following services (for an extra fee):

1. ☐ Addressee's Address
2. ☐ Restricted Delivery

Consult postmaster for fee.

3. Article Addressed to:

BARBARA ELLEN ZIPKIN, M.D.



4a. Article Number
Z434 973287

4b. Service Type
☐ Registered ☑ Certified
☐ Express Mail ☐ Insured
☐ Return Receipt for Merchandise ☐ COD

7. Date of Delivery
1-29

5. Received By: *(Print Name)*

8. Addressee's Address *(Only if requested and fee is paid)*

6. Signature: *(Addressee or Agent)*
X

PS Form 3811, December 1994 102595-98-B-0229 Domestic Return Receipt

Thank you for using Return Receipt Service.

issue and renew licenses to practice medicine to those individuals who qualify for licensure pursuant to current and effective statutes and administrative regulations. See, Kendall v. Malcolm, 98 Ariz. 329, 334, 404 P.2d 414, 417 (1965); and, Boyce v. City of Scottsdale, 157 Ariz. 265, 267, 756 P.2d 934, 936 (App. 1988). If an agency of the State takes action that is beyond its legal authority, the action is void. See, Magma Copper Co. v. Arizona State Tax Commission, 67 Ariz. 77, 86-87, 191 P.2d 169, 175 (1948).

BOMEX staff started sending notices to physicians for renewal of limited medical licenses for 1999 on October 30, 1998. Due to the aforementioned legal reasons, renewal of limited licenses should not have been processed by BOMEX staff for 1999. Therefore, a physician currently practicing medicine in Arizona solely pursuant 1999 limited license is doing so under the authority of a voidable BOMEX limited license. The practice of medicine by a person not lawfully licensed to practice by BOMEX or otherwise exempt from licensure pursuant to statute, is a Class (5) felony criminal offense. However, please read carefully the explanation of legal analysis provided at page 3, paragraph 3, regarding your conditional and limited legal right to continue practicing medicine pursuant to the limited license issued to you.

ALTERNATIVE COURSES OF ACTION AVAILABLE TO YOU

(1) If you want to obtain an unlimited BOMEX medical license to replace your voidable limited license, you will need to make application in the same manner as any new applicant. Specifically, see A.R.S. § 32-1422 through § 32-1428, which appear in the 1998-99 BOMEX medical directory at pages 18-21.

In many instances, physicians currently holding a BOMEX limited license may want to apply for a standard unlimited BOMEX license pursuant to BOMEX statute A.R.S. § 32-1426 (licensure by endorsement). However, you should carefully review the requirements of A.R.S. § 32-1426 and specifically the requirements of A.R.S. § 32-1426(C) (as effective from November 1, 1998) which specifies that BOMEX licensure by endorsement can not be based on passage of a prior written examination or combination of examinations that pre-dates your new application by ten (10) years. In other words, applicants for licensure by endorsement whose passing examination scores for those examinations listed at A.R.S. § 32-1426(A)(1) and (2) are more than ten (10) years old, as of the date of application to BOMEX, must take and pass the "special purpose licensing examination" (SPEX) with a score of at least 75%, pursuant to A.R.S. § 32-1426(C) and § 32-1401(18)(b).[2]

Physicians who do not meet the criteria for standard BOMEX licensure by endorsement will have to satisfy the licensure by examination requirements at A.R.S. § 32-1425.

[2] Please consult your BOMEX "Medical Directory" for 1998-99 to review the aforementioned statutes in their entirety which appear in the yellow pages of the directory, pages 11-32.

(2) Pursuant to A.R.S. § 32-1428, the BOMEX executive director may issue to qualified applicants a temporary license to practice medicine; but the temporary license may only be issued to an applicant seeking licensure by endorsement whose application is complete except for taking and passing the SPEX examination as required by A.R.S. § 32-1426(C). Before issuing a temporary license under this statute, the applicant must:

> (1) submit a completed BOMEX application for licensure by endorsement and expressly request a temporary license; and, (2) pay all required fees; and, (3) provide proof of registration for the SPEX with a definite date for taking the SPEX.

Note that the temporary license expires on the last day of the month in which the SPEX grades of the applicant are reported to BOMEX and may not be extended, pursuant to A.R.S. § 32-1428(B), (C). The applicant for a temporary license must take the SPEX examination within the time period established by the administrator of the SPEX, i.e., Federation of State Medical Boards. Currently physicians registered for the SPEX are required by the SPEX administrator to take the examination within 90 days from date of notification from the SPEX administrator that registration was approved.

If the applicant receives a temporary license and does not take the SPEX examination within the aforementioned time period, the temporary license shall expire at the end of the month when the SPEX examinations scores are reported, for the last month wherein the applicant could have taken the examination, as required by A.R.S. § 32-1428(C). Pursuant to A.R.S. § 32-1428(C), the temporary license may not be extended beyond the previously described time period.

(3) Pursuant to the Administrative Procedures Act at A.R.S. § 41-1092.11(B), when a State agency determines that a license issued by the agency is null and void, *the decision of the State agency (i.e., BOMEX) is not effective and final until the State agency "... provides the licensee with notice and an opportunity for a hearing."*

A physician holding a voidable BOMEX 1999 limited license will in the future receive from BOMEX notice of a specific date, time and location of the hearing at which the physician may contest BOMEX's decision as reported in this letter. Said notice will be served on the physician at least thirty (30) days before the hearing, pursuant to A.R.S. § 41-1092.05(D). In the event that a limited licensee physician fails to enter a written response or appearance at said hearing, the Board's decision in regard to the voiding of the physician's limited license shall become final and not appealable. See, Rosen v. Board of Medical Examiners, 185 Ariz. 139, 912 P.2d 1368 (App. 1995).

In other words, this matter will be treated as a contested case pursuant to A.R.S. § 41-1092.05(A)(2); and, the case will either be scheduled for hearing before the Board or referred to the Office of Administrative Hearings to conduct the hearing. Pursuant to A.R.S. § 41-1092.11, BOMEX's notification to you by this letter of the nullification of

1999 limited licensure shall not be final and effective until after the conclusion of the administrative hearing process. Therefore, while this matter is pending final conclusion of the administrative hearing process it is the policy of BOMEX that a limited licensee physician may continue to practice medicine in Arizona within the limits of his or her area of medical specialization, pending final disposition of the physician's specific contested case.

(4) Physicians holding 1999 limited licenses may elect to follow simultaneously alternative (3), in conjunction with either alternatives (1) or (2). However, if you wish to obtain a new unlimited standard BOMEX license, you should act promptly. See the attached form for review and completion by you, if you want to apply for BOMEX's standard unlimited physician license.

CONCLUSION

The Board's policy as described above in regard to the termination of its authority to issue limited licenses to practice in a certified area of medical specialization is dictated not only by the language of the Board's statutes but by recent Arizona appellate court case law. Specifically, in the case of Hansson v. Arizona State Board of Dental Examiners, reported at 283 Ariz. Adv. Rpt. 29 (Ariz. Court of Appeals, Division One, Opinion issued 12/3/98), the Arizona Court of Appeals held that because of the expiration and repeal of a statute authorizing the Board of Dental Examiners to issue licenses for the limited practice of dentistry (i.e., designated area of specialization), the Dental Board was prohibited from renewing Dr. Hansson's pre-existing limited Dental Board license. On advice of the Office of the Arizona Attorney General, it has been decided that the legal analysis by the Court of Appeals in the Hansson decision also supports BOMEX's conclusion regarding the expiration of BOMEX's authority to issue limited licenses pursuant to A.R.S. § 32-1426(C)(i.e., authorizing limited licensure for area of medical specialization).

On January 13, 1999, the members of the Board of Medical Examiners conducted a special public meeting regarding this topic. At the meeting the Board received legal advice and considered alternative solutions to this problem. The Board members unanimously authorized issuance of this letter. Furthermore, the Board voted to authorize the Chairman and Executive Director to initiate communication with Legislative leadership to explore obtaining legislation to remedy this legal problem. You will be advised if progress is made in that regard.

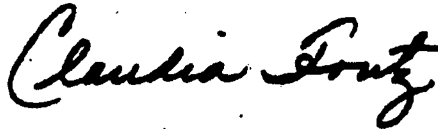
In closing, please be advised that the expiration of the Board's authority to issue limited medical specialty licenses on November 1, 1998, occurred pursuant to the mandate of the Legislature which originally created this special licensing authority in 1995. In other words, the Board and its Executive Director did not initiate this statutory change and deletion of the Board's authority to issue limited licenses for medical practice. Nevertheless, on behalf of the Board and BOMEX staff, we wish to apologize for not

advising physicians holding limited medical practice licenses sooner of the implications of the change in the Board's statutory authority.[3]

The legal opinions expressed within this letter reflect the position of the Board and its legal counsel; and therefore, you may wish to seek the advice of legal counsel before making a final decision regarding the alternatives available to you. Correspondence from you to BOMEX concerning this topic should be directed to:

Arizona Board of Medical Examiners
Licensing Section/Limited Licenses
1651 E. Morten, Suite 210
Phoenix, Arizona 85020

Sincerely,



Claudia Foutz
Executive Director

Enclosure (BOMEX FORM)

Z 434 973 287

US Postal Service
Receipt for Certified Mail
No Insurance Coverage Provided.
Do not use for International Mail (See reverse)

Sent to	
Street & Number	
Post Office, State, & ZIP Code	
Postage	$
Certified Fee	
Special Delivery Fee	
Restricted Delivery Fee	
Return Receipt Showing to Whom & Date Delivered	
Return Receipt Showing to Whom, Date, & Addressee's Address	
TOTAL Postage & Fees	$
Postmark or Date	

PS Form 3800, April 1995

[3] Please note that the BOMEX Medical Directory (sent to all BOMEX licensed physicians) for the years 1996-97, at pages 22-23, and 1997-98, at pages 24-25, reprinted A.R.S. § 32-1426 (Licensure by endorsement) with an italicized notation stating that the statute would be effective as printed until November 2, 1998, and then reprinting the statute as amended and effective after that date. The intent in publishing the statute in this manner in the Medical Directory was to provide some notification to limited licensee physicians of the statutory change.

May 8, 1998

Barbara Ellen Zipkin, M.D.

Dear Dr. Zipkin:

Congratulations! Your certificate to practice medicine in the State of Arizona, License No. 26425, issued on, May 8, 1998 is enclosed with your wallet registration card for the current year.

Please be advised that **annual re-registration is mandatory** on a calendar-year basis. Arizona statutes provide that each licentiate renew registration on January 1st of every year. To maintain a current license, you are required to pay an annual renewal fee. Notification of renewal will be mailed to your address of record on or about November 1st of each year. Failure to re-register will result in statutory expiration of your license. It is your responsibility to keep the Board informed of address changes. Arizona Revised Statutes §32-1435 (B) provides that:

> "Each person holding a current license to practice medicine in this state shall promptly and in writing inform the Board of his current residence and office address and of each change in his residence and office address that may later occur."

Enclosed for your information is the section of the Arizona Medical Practice Act which pertains to Unprofessional Conduct. It is the responsibility of all licentiates in practice in Arizona to report directly to the Board of Medical Examiners any misconduct, unprofessional conduct or medical incompetence on the part of your colleagues which may come to your attention. According to A.R.S. § 32-1451 (A), failure to do so is actionable against your license to practice. You will receive a copy of the Arizona State Medical Directory published annually by the Board which contains the Arizona Medical Practice Act. It is suggested that you familiarize yourself with such prior to establishing your practice in Arizona.

In addition, included with this letter is information regarding Continuing Medical Education requirements and Prescription Form requirements.

Please contact Becky Drew, Licensing Manager, Extension 7101, should you have any questions.

Sincerely,

BOARD OF MEDICAL EXAMINERS STATE OF ARIZONA

Donna Nemer
Acting Deputy Director

12/94

Enclosures

SENDER:
- Complete items 1 and/or 2 for additional services.
- Complete items 3, 4a, and 4b.
- Print your name and address on the reverse of this form so that we can return this card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit.
- Write *"Return Receipt Requested"* on the mailpiece below the article number.
- The Return Receipt will show to whom the article was delivered and the date delivered.

I also wish to receive the following services (for an extra fee):

1. ☐ Addressee's Address
2. ☐ Restricted Delivery

Consult postmaster for fee.

3. Article Addressed to:

4a. Article Number 2212 741 196

4b. Service Type

☐ Registered ☐ Certified
☐ Express Mail ☐ Insured
☐ Return Receipt for Merchandise ☐ COD

7. Date of Delivery

5. Received By: *(Print Name)*

8. Addressee's Address *(Only if requested and fee is paid)*

6. Signature: *(Addressee or Agent)*
X

PS Form **3811**, December 1994

Domestic Return Receipt

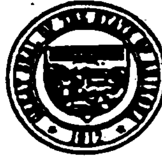
Is your **RETURN ADDRESS** completed on the reverse side?

Thank you for using Return Receipt Service.

Philip E. Keen, MD
CHAIRMAN

Ram R. Krishna, MD
Vice-CHAIRMAN

Carole A. Crevier
SECRETARY



Donna Nemer
Acting Deputy Director

Arizona Board of Medical Examiners

1651 East Morten Ave., Suite 210 Phoenix, Arizona 85020 Telephone (602) 255-3751 FAX (602) 255-1848

April 28, 1998

Barbara Zipkin, M.D.

Dear Dr. Zipkin:

The Board of Medical Examiners, State of Arizona, is pleased to inform you that your application and credentials for a license to practice medicine in the State of Arizona has been approved.

Arizona Revised Statutes provide for an initial registration of each licentiate and the certificate of license may not be issued until this is in hand. Please complete the enclosed card and return it to the Board of Medical Examiners, State of Arizona, 1651 E. Morten Avenue, Suite 210, Phoenix, AZ 85020. In order for your license to be issued, this card must be received by 12 noon Thursday of each week. Your license may then be issued the following day, Friday. **YOU MUST NOT COMMENCE THE PRACTICE OF MEDICINE IN THE STATE OF ARIZONA UNTIL A LICENSE NUMBER HAS BEEN ISSUED TO YOU.** RENEWALS ARE JANUARY 1, OF EACH YEAR.

The Board publishes an annual directory of all licentiates in this State, which is distributed around October of each year. Information for this publication is taken from the registration card which you complete. Home addresses and telephone numbers are not published, **unless this is the only address which you provide to the Board.** The deadline for receipt of address changes for inclusion in this directory is **July 31st** of each year. If you anticipate a move before that date, please indicate your new address(es) with the effective date as well as your current address(es).

Any questions you have regarding this communication may be directed to me, at Ext. 7100. Thank you for your cooperation.

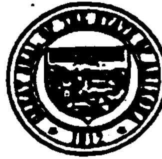
Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Krystal Fife
Licensing Technician

[approval.ltr]

Philip E. Keen, MD
CHAIRMAN
Ram R. Krishna, MD
Vice- CHAIRMAN
Carole A. Crevier
SECRETARY



Donna Nemer
Acting Deputy Director

Arizona Board of Medical Examiners

1651 East Morten Ave.. Suite 210 Phoenix. Arizona 85020 Telephone (602) 255-3751 FAX (602) 255-1848

April 17, 1998

Barbara E. Zipkin, M.D.

Dear Dr. Zipkin:

This will acknowledge receipt of your application for licensure to practice medicine in the State of Arizona through Written Examination.

Our receipt no.:A 86508 covering the statutory fee of $450.00 is enclosed.

To complete the processing of your application, the following information and/or documentation must be received by the Board:

4/29/98

For your information, Form III Postgraduate Training Certification form from North ShoreUniversity Hospital; Manhasset, NY for the period of July 1, 1976 to June 30, 1980 was returned for their official seal.

Please be advised that final action on your application cannot be taken until the above is in your file of record. It is your responsibility to ensure the above is received by the Board.

Further, please be advised that applications not fully completed within one year from this date, including participation in written SPEX/USMLE Examination (if applicable), are considered withdrawn.

Your application is being processed routinely and you will be advised as to the Board's decision relative to the granting of an Arizona license. If you have any questions regarding this communication, please contact me at Ext. 7100. Thank you for your cooperation.

Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Krystal Fife
Licensing Technician

Enclosure

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGO805ENCY PETE WILSON, Governor

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 56
Sacramento, CA 95825-3236
(916) 263-2360 FAX (916) 263-2487

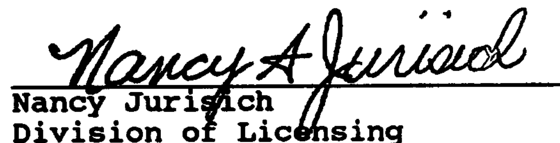
March 25, 1998

Arizona State Board of Medical Examiners
1651 E. Morten Ave, Ste 210
Phoenix, AZ 85020

TO WHOM IT MAY CONCERN:

This is to verify that Dr. Barbara Ellen Zipkin, was issued California physician and surgeon's certificate #G41246, on 11/26/79, based on National Board Credentials. The license is current with renewal fees paid through 4/30/99.

There is no current record of accusation and/or disciplinary activity.



Nancy Jurisich
Division of Licensing

To expedite the verification process, the above is the standard format used by the Medical Board of California.

SEAL

RECEIVED B.O.M.E.X.
APR -1 98

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AG0805ENCY PETE WILSON, *Governor*

MEDICAL BOARD OF CALIFORNIA
0256LICENSING PROGRAM
1426 Howe Avenue, Suite 56
0256Sacramento, CA 95825-3236
(916) 263-0921 FAX (916) 263-2487

March 23, 1998

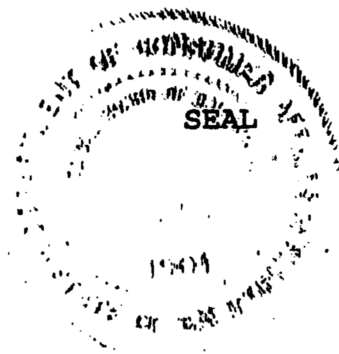
Arizona State Board of Medical Examiners
1651 E. Morten Ave, Ste 210
Phoenix, AZ 85020

TO WHOM IT MAY CONCERN:

This is to verify that Dr. BARBARA ELLEN ZIPKIN, was issued California physician and surgeon's certificate #G 41246 on 11/26/79, based on National Board Credentials. The license is current and renewal fees are paid through 04/30/99. There is no current record of accusation and/or disciplinary activity.

Susie Baldizan
Division of Licensing

To expedite the verification process, the above is the standard format used by the Medical Board of California.

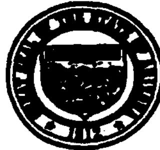


RECEIVED B.O.M.E.X.
MAR 30 98

Philip E. Keen, MD
CHAIRMAN

Ram R. Krishna, MD
Vice- CHAIRMAN

Carole A. Crevier
SECRETARY



Donna Nemer
Acting Deputy Director

Arizona Board of Medical Examiners

1651 East Morten Ave., Suite 210 Phoenix, Arizona 85020 Telephone (602) 255-3751 FAX (602) 255-1848

March 30, 1998

North Shore University Hospital
Attn: S. Theodore Horwitz, M.D.
Residency Program Director
Dept. of OB/GYN
300 Community Drive
Manhasset, NY 11030

RE: Barbara Zipkin, M.D.

4/15/98

Dear Dr. Horwitz:

Enclosed, please find the Form III Postgraduate Training Certification form for Dr. Zipkin.

Please affix your official hospital stamp or seal and return the same to the address above. If you do not have an official hospital stamp or seal, please indicate.

Thank you for your prompt attention to this matter.

If you have any questions, please contact me at (602) 255-3751 ext. 7100.

Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Krystal M. Fife
Licensing Technician

Enclosures

AFFXSEA.DOC/KMF

Original

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CUSTOMER SERVICE UNIT
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, ZIPKIN BARBARA E WAS ISSUED LICENSE/CERTIFICATE NUMBER 131258 FOR THE PRACTICE OF MEDICINE ON 07/01/77.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: [redacted]
SCHOOL ATTENDED: NORTHWESTERN UNIVERSITY
DATE OF GRADUATION: 01/01/75
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:
B NATIONAL BOARD CERTIFICATE #165118 DATED 01/03/77

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: NO REG PERIOD ENDS:
ADDRESS: APT 4 1013 10TH STREET
SANTA MONICA CA 90403-0000
DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I FRANK GEBOSKY, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

Frank Gebosky 03/18/98
PRINCIPAL CLERK

OP026 054

RECEIVED B.O.M.E.X.
MAR 24 98

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 EAST MORTEN AVENUE, SUITE #210, PHOENIX, ARIZONA 85020

(602) 255-3751

MAR 10 1998

The Physician must complete and forward this form to the *FEDERATION OF STATE MEDICAL BOARDS* at the address below:

Coordinator, Disciplinary Data Bank
THE FEDERATION OF STATE MEDICAL BOARDS
400 Fuller Wiser Road
Euless, Texas 76039

The Arizona Board of Medical Examiners requests a disciplinary search concerning the following individual:

NAME: Zipkin, Barbara Ellen
(Print or Type) (Last) (First) (Middle)

BIRTH DATE:

Medical School of Graduation and Branch Location: Northwestern Univ., Chicago, Ill.

Date of Graduation: 6/76

Physician's Signature:

Date signed by Physician: 3/2/98

FEDERATION OF STATE MEDICAL BOARDS COMMENTS:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

MAR 18 1998

JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

After completion by the Federation of State Medical Boards return this form directly to: The Board of Medical Examiners of the State of Arizona, 1651 E. Morten Ave. Ste 210, Phoenix, AZ 85020

RECEIVED B.O.M.E.X.

MAR 20 98

KAISER PERMANENTE
Southern California Permanente Medical Group

CLINIC PROGRESS RECORD

PT. STREET ADDRESS

PT. HOME PHONE NUMBER

PT. WORK PHONE NUMBER

NAME

MEDICAL RECORD NO. ZIP CODE

COV REG LXP INJ ALL VIS ADD DRUG

GROUP NUMBER SEX DEP BIRTHDATE FAMILY ACCOUNT NO.

Date / Service	Treatment

Barbara Zipkin, M.D.

Arizona Board of Medical
Examiners
1651 E. Morten
Ste. 210
Phoenix, AZ. 85020

Dear Sirs,

I am currently in the full time practice of OB-Gyn, am Board Certified by the American College of OB-Gyn, and am an instructor in an accredited residency teaching program. I would like to apply for an Arizona license under these exemptions, the Board Certification Endorsement. I will make the stipulation that I shall not practice outside of this specialty.

Thank you,

Sincerely,
Barbara Zipkin M.D.
[signature]

RECEIVED B.O.M.E.X.
FEB 17 93

12-2057 (6-84)

CLINIC PROGRESS RECORD

Date / Service	Treatment

ARIZONA BOARD OF MEDICAL EXAMINERS

STIPULATION PURSUANT TO A.R.S. §32-1426(C)

A.R.S. §32-1426(C) as amended 1995, states that an applicant for licensure by endorsement who is certified or recertified by a specialty board that is recognized by the American Board of Medical Specialties is exempt from the licensing examination required by A.R.S. §32-1426(C) provided that the applicant is ~~currently a full-time instructor in an accredited residency teaching~~ program or is in full time practice with current continuing medical education credits. A physician who is licensed under this exemption is required to stipulate to the Board of Medical Examiners that the physician shall not practice outside of that specialty.

Pursuant to A.R.S. §32-1426(C), the undersigned applicant stipulates to the Arizona Board of Medical Examiners that he/she is currently certified or recertified by the following Specialty Board that is recognized by the American Board of Medical Specialties:

American Board of Obstetrics & Gynecology
Name of Specialty Board Recognized by American Board of Medical Specialties

Obstetrics & Gynecology
Specialty

12/9/83
Date of Certification or Recertification

Applicant stipulates that if applicant is granted a license pursuant to the exemption, applicant shall not practice medicine outside of the specialty stated above.

Applicant understands that violation of this stipulation may be grounds for disciplinary action, including revocation of license.

Barbara Zipkin
Print Name of Applicant

[signature]
Signature

2/9/98
Date

RECEIVED B.O.M.E.X.
FEB 17 98

ARIZONA BOARD OF MEDICAL EXAMINERS

AFFIDAVIT

A.R.S. §32-1426(c)

STATE OF California)

COUNTY OF Los Angeles)

I hereby certify that I am:
(check one)

☒ IN THE FULL-TIME PRACTICE OF MEDICINE AT THE FOLLOWING ADDRESS 4900 Sunset Blvd., L.A., Ca. 90028 WITH CURRENT CONTINUING MEDICAL EDUCATION CREDITS.

OR

☐ CURRENTLY A FULL-TIME INSTRUCTOR IN THE FOLLOWING __________ __________ ACCREDITED RESIDENCY TEACHING PROGRAM. LOCATED AT __________
(Name of Institution)

Dated this 10TH day of February, 1998.

Barbara Zipkin, M.D.
(Print or Type Full Name)

[signature]
(Signature)

Sworn to before me this 10TH day of FEBRUARY 1998

[signature]
(Notary Signature) HELAINE R. PANSEK

[SEAL]

My Commission expires: June 4, 2000

07/95

RECEIVED B.O.M.E.X.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020, (602) 255-3751

SPEX OR AMERICAN BOARD ENDORSMENT PRE-APPLICATION ATTACHMENT

☐ I wish to register for the Special Purpose Examination (SPEX).Please send me the application and instructions for completion as well as any other required forms

☒ I wish to be exempt from the SPEX Exam and apply through American Board Certification, I will stipulate with the Board to practice within my specialty field only. Please send me the application and instructions for completion as well as other required forms.

NAME: Barbara Zipkin, M.D.
(please print)

SIGNATURE: [signature]

DATE: 2/9/98

RECEIVED B.O.M.E.X.

Southern California Permanente Medical Group
4900 Sunset Boulevard
Los Angeles, California 90027

April 27, 1998

Arizona Medical Board

Regarding; Barbra Zipkin, MD

Dear Persons,

Dr. Zipkin in currently active staff at the Los Angeles Kaiser Foundation Hospital. She is also an attending and an active participant of the faculty for the Department of Obstetrics and Gynecology at Kaiser Permanente, Los Angeles Medical Center.

She has been with the Southern California Permanente Medical Group for 19 years. I have worked with Dr. Zipkin since she first came to the medical group at Los Angeles and highly recommend this physician for licensing.

Barbra Zipkin is a physician of high moral character and integrity. She is intelligent, hardworking and trustworthy. I am not aware of disciplinary actions or any substance abuse issues. She is a very highly regarded and respected physician in my department.

If you require further information, please do not hesitate to call me directly at 213 783 1774.

Sincerely,

Faustina Nevarez, M.D.
Chief OBGYN Kaiser LAMC

orig is forthcoming

Southern California Permanente Medical Group
4900 Sunset Boulevard
Los Angeles, California 90027

Arizona State
Medical Board

602 255 1848

Southern California Permanente Medical Group
4900 Sunset Boulevard
Los Angeles, California 90027

Arizona State
Medical Board

602 255 1848

Southern California Permanente Medical Group
4900 Sunset Boulevard
Los Angeles, California 90027

April 27, 1998

Arizona Medical Board

Regarding; Barbra Zipkin, MD

Dear Persons,

Dr. Zipkin in currently active staff at the Los Angeles Kaiser Foundation Hospital. She is also an attending and an active participant of the faculty for the Department of Obstetrics and Gynecology at Kaiser Permanente, Los Angeles Medical Center.

She has been with the Southern California Permanente Medical Group for 19 years. I have worked with Dr. Zipkin since she first came to the medical group at Los Angeles and highly recommend this physician for licensing.

Barbra Zipkin is a physician of high moral character and integrity. She is intelligent, hardworking and trustworthy. I am not aware of disciplinary actions or any substance abuse issues. She is a very highly regarded and respected physician in my department.

If you require further information, please do not hesitate to call me directly at 213 783 1774.

Sincerely,

Faustina Nevarez, M.D.
Chief OBGYN Kaiser LAMC

Zipkin, Barbara

PRELIMINARY QUESTIONNAIRE

#4794

THIS IS NOT AN APPLICATION

To respond accurately to your recent inquiry, we will need the answers to all of the following questions to determine your eligibility for Arizona licensure. Unless the Preliminary Form is completed in full and all questions answered, it cannot be evaluated, nor an application sent to you. Return the completed form as soon as possible to: ARIZONA BOARD OF MEDICAL EXAMINERS, 1651 East Morten Avenue, Suite 210 Phoenix, Arizona 85020. **PLEASE PRINT/TYPE ALL INFORMATION.**

Full Legal Name: Barbara (FIRST) Ellen (MIDDLE) Zipkin (LAST)

Current Office Address: 4900 Sunset Blvd

City: L.A. State: Ca. Zip Code: 90028 Area Code: (213) Phone: 783-4423

MEDICAL SCHOOL: Name: Northwestern University 616-06

City and State: Chicago, Ill. Date of Degree: 12/75

If transferred from other medical school, please indicate name: ∅

Name of any medical school attended but did not graduate or transfer from: ∅

5th PATHWAY PROGRAM: U.S. Medical School: ∅

HOSPITAL: City: State:

TERM: Started: (MONTH AND YEAR) Completed: (MONTH AND YEAR)

INTERNSHIP: (List U.S. & Canadian only)

HOSPITAL: North Shore Univ. Hospital City: Manhasset State: N.Y.

TERM: Started: 7/76 (MONTH AND YEAR) Completed: 6/77 (MONTH AND YEAR) Specialty Field: OB-Gyn

RESIDENCY/FELLOWSHIP: (List U.S. & Canadian only)

HOSPITAL: North Shore Univ. Hospital City: Manhasset State: N.Y.

TERM: Started: 7/77 (MONTH AND YEAR) Completed: 6/80 (MONTH AND YEAR) Specialty Field: OB-Gyn

RESIDENCY/FELLOWSHIP: (List U.S. & Canadian only)

HOSPITAL: ∅ City: State:

TERM: Started: (MONTH AND YEAR) Completed: (MONTH AND YEAR) Specialty Field:

FOR OFFICE USE ONLY

Green APPLICATION FORWARDED 2/20/98

APPLICATION & FORMS I II III AMA FS

LICENSES 2 HOSPITALS 0 MAE 0

RECEIVED B.O.M.E.X.

FEB 17 98

CLINICAL INSTRUCTOR - ASSISTANT PROFESSOR OR HIGHER (U.S. & Canadian only)

TEACHING HOSPITAL: Kaiser Foundation Hosp. - LA Medical Center

City: L.A. State: Ca.

MEDICAL SCHOOL AFFILIATE: Ø

TERM: Started: ______ (MONTH AND YEAR) Completed: ______ (MONTH AND YEAR)

Specialty Field: OB-Gyn.

(NOTE: Attach separate list for additional Residency/Fellowship/Clinical Instructor)

FOREIGN MEDICAL SCHOOL GRADUATES: ECFMG Cert No.: Ø Date Issued: ______

CLINICAL WRITTEN EXAMINATION: Refer to last page for required FLEX/SPEX scores.

Please indicate which examinations you have successfully passed:

NATIONAL BOARD	USMLE	FLEX (taken after 01/01/85)
Part I 1974 (date)	Step I ______ (date)	Comp. I ______ (date)
Part II 1975 (date)	Step II ______ (date)	Comp. II ______ (date)
Part III 1977 (date)	Step III ______ (date)	

FLEX examination taken prior to January 1, 1985 ______ Did you received a minimum grade of 75? ______

Were grades achieved all in one sitting? Yes ______ No ______

State Board exam? Name of State Ca. License No ______ Date Issued ______

LMCC(Canadian) ______ Cert No. ______ Date Issued ______

SPECIAL PURPOSE EXAMINATION:

(SPEX) ______ Date (SPEX) examination taken: ______

Did you receive a minimum grade of seventy-five (75)? ______

Are you a Diplomat of any of the American Medical Specialty Board(s)? Yes ✓ No ______

If "Yes", which Board(s) Obstetrics + Gynecology

Have you completed the educational requirements for any of the American Medical Specialty Board(s)?

Yes ______ No ______ If "Yes", which Board(s)? ______

LICENSE: List all States or Provinces in which you have ever held licensure.

(1) California (2) New York (3) ______ (4) ______ (5) ______
(6) ______ (7) ______ (8) ______ (9) ______ (10) ______

LIST all hospital affiliations and locations for the past five (5) years (Other than Postgraduate Training Hospitals): Please list all hospital affiliations (including moonlighting) and medical agencies of employment, e.g., physician placement group; emergency medical group; radiology group, etc.:

Ø

(NOTE: Attach separate list for additional hospital affiliations/medical agencies)

PRACTICE: City and State where you now practice: L.A., Calif.
Date above practice was established: 8/80

RECEIVED B.O.M.E.X.
FEB 17 93

U.S. CITIZENSHIP:

(X) Birth
( ) Naturalization
( ) Hold Permanent Immigrant Status

BIRTHPLACE: [redacted] **DATE OF BIRTH:** [redacted]

MILITARY (United States Only):

( ) Army
( ) Navy
( ) Air Force
( ) Marine Corps
( ) USPHS
( ) Coast Guard

Dates of Active Duty: Ø ____ Type of Discharge: ____

Has any formal disciplinary or rehabilitation action including reprimand, censure, probation, restriction, limitation, suspension or revocation been taken against your license in any State/Province? Yes____ NO ✓

Have you ever entered into a written consent agreement or stipulation with a State/Province licensing or disciplinary agency? Yes____ No ✓

If "Yes", indicate State/Province ____

Reason for action and action taken: ____

(NOTE: Attach separate sheet, if necessary)

Have you ever been convicted of Medicare/Medicaid fraud? Yes____ No ✓

If "Yes", when? ____ Where? ____

Have your prescription/dispensing/or administration abilities ever been denied, restricted or modified by a Federal/State/Province government agency? Yes____ No ✓

If "Yes", when? ____ Where? ____ and by which agency? ____

Have you ever had a license denied by any State/Province? Yes ____ No ✓

Reason for denial: ____

Have you ever been involved in any malpractice matter which resulted in a settlement or judgment against you in excess of $20,000? Yes____ No ✓

Have you ever had hospital privileges revoked; denied; suspended or restricted in any way? Yes____ No ✓

If "Yes", name and address of hospital(s) ____

(NOTE: Attach separate sheet, if necessary)

I DECLARE UNDER PENALTY OF PERJURY that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this Preliminary Questionnaire, I hereby agree that such shall constitute cause for the denial of my eligibility to apply for licensure as an allopathic physician in the State of Arizona.

SIGNATURE: [signature] **M.D. DATE:** 2/9/98

RECEIVED B.O.M.E.X.
FEB 17 98

FEB 05 1998 **PRELIMINARY QUESTIONNAIRE**

Zipkin, Barbara

4876

THIS IS NOT AN APPLICATION

To respond accurately to your recent inquiry, we will need the answers to all of the following questions to determine your eligibility for Arizona licensure. Unless the Preliminary Form is completed in full and all questions answered, it cannot be evaluated, nor an application sent to you. Return the completed form as soon as possible to: ARIZONA BOARD OF MEDICAL EXAMINERS, 1651 East Morten Avenue, Suite 210 Phoenix, Arizona 85020. **PLEASE PRINT/TYPE ALL INFORMATION.**

Full Legal Name: Barbara Ellen Zipkin
(FIRST) (MIDDLE) (LAST)

Current Office Address: 4900 Sunset Blvd.

City: L.A. State: Ca Zip Code: 90028 Area Code: (213) Phone: 783-4423

MEDICAL SCHOOL: Name: Northwestern Univ. 016-06

City and State: Chicago Ill. Date of Degree: 12/75

If transferred from other medical school, please indicate name: ∅

Name of any medical school attended but did not graduate or transfer from: ∅

5th PATHWAY PROGRAM: U.S. Medical School:

HOSPITAL: City: State:

TERM: Started: (MONTH AND YEAR) Completed: (MONTH AND YEAR)

INTERNSHIP: (List U.S. & Canadian only)

HOSPITAL: North Shore Univ. Hospital City: Manhasset State: N.Y.

TERM: Started: 7/76 (MONTH AND YEAR) Completed: 6/77 (MONTH AND YEAR) Specialty Field: Ob-Gyn.

RESIDENCY/FELLOWSHIP: (List U.S. & Canadian only)

HOSPITAL: North Shore Univ. Hosp. City: Manhasset State: N.Y.

TERM: Started: 7/77 (MONTH AND YEAR) Completed: 6/80 (MONTH AND YEAR) Specialty Field: Ob-Gyn.

RESIDENCY/FELLOWSHIP: (List U.S. & Canadian only)

HOSPITAL: ∅ City: State:

TERM: Started: (MONTH AND YEAR) Completed: (MONTH AND YEAR) Specialty Field:

FOR OFFICE USE ONLY

APPLICATION FORWARDED ____ 19__

APPLICATION & FORMS I II III IV AMA FS

LICENSES ____ HOSPITALS ____ NAE ____

Sent Stip & V List 2/12/98

already input

RECEIVED B.O.M.E.X.

FEB 11 98

CLINICAL INSTRUCTOR - [ASS]ISTANT PROFESSOR OR HIGHER ([Firs]t U.S. & Canadian only)

TEACHING HOSPITAL: Kaiser Permanente

City: L.A. State: Ca.

MEDICAL SCHOOL AFFILIATE: U.S.C.

TERM: Started: ______ (MONTH AND YEAR) Completed: ______ (MONTH AND YEAR)

Specialty Field: Ob-Gyn

(NOTE: Attach separate list for additional Residency/Fellowship/Clinical Instructor)

FOREIGN MEDICAL SCHOOL GRADUATES: ECFMG Cert No.: — Date Issued: ______

CLINICAL WRITTEN EXAMINATION: Refer to last page for required FLEX/SPEX scores.

Please indicate which examinations you have successfully passed:

NATIONAL BOARD	USMLE	FLEX (taken after 01/01/85)
Part I 1974 (date)	Step I ______ (date)	Comp. I ______ (date)
Part II 1976 (date)	Step II ______ (date)	Comp. II ______ (date)
Part III 1977 (date)	Step III ______ (date)	

FLEX examination taken prior to January 1, 1985 ______ Did you received a minimum grade of 75? ______

Were grades achieved all in one sitting? Yes ✓ No ______

State Board exam? Name of State Calif. License No G-41246 Date Issued 11/26/79

LMCC(Canadian) ______ Cert No. ______ Date Issued ______

SPECIAL PURPOSE EXAMINATION:

(SPEX) — Date (SPEX) examination taken: ______

Did you receive a minimum grade of seventy-five (75)? —

Are you a Diplomat of any of the American Medical Specialty Board(s)? Yes X No ______
If "Yes", which Board(s) Ob-Gyn.

Have you completed the educational requirements for any of the American Medical Specialty Board(s)?

Yes X No ______ If "Yes", which Board(s)? ______

LICENSE: List all States or Provinces in which you have ever held licensure.

(1) N.Y. (2) Ca. (3) ______ (4) ______ (5) ______
(6) ______ (7) ______ (8) ______ (9) ______ (10) ______

LIST all hospital affiliations and locations for the past five (5) years (Other than Postgraduate Training Hospitals): Please list all hospital affiliations (including moonlighting) and medical agencies of employment, e.g., physician placement group; emergency medical group; radiology group, etc.:

Kaiser Permanente Hospital - Sunset Blvd., LA, CA 90028

(NOTE: Attach separate list for additional hospital affiliations/medical agencies)

PRACTICE: City and State where you now practice: Los Angeles, Ca.
Date above practice was established: 8/80

RECEIVED D.O.M.E.X.
FEB 11 98

U.S. CITIZENSHIP:

(X) Birth
( ) Naturalization
( ) Hold Permanent Immigrant Status

BIRTHPLACE: [redacted] **DATE OF BIRTH:** [redacted]

MILITARY (United States Only):

( ) Army
( ) Navy
( ) Air Force
( ) Marine Corps
( ) USPHS
( ) Coast Guard

Dates of Active Duty: ∅ Type of Discharge:

Has any formal disciplinary or rehabilitation action including reprimand, censure, probation, restriction, limitation, suspension or revocation been taken against your license in any State/Province? Yes____ NO ✓

Have you ever entered into a written consent agreement or stipulation with a State/Province licensing or disciplinary agency? Yes____ No ✓

If "Yes", indicate State/Province

Reason for action and action taken:

(NOTE: Attach separate sheet, if necessary)

Have you ever been convicted of Medicare/Medicaid fraud? Yes____ No ✓

If "Yes", when?

Where?

Have your prescription/dispensing/or administration abilities ever been denied, restricted or modified by a Federal/State/Province government agency? Yes____ No ✓

If "Yes", when? Where? and by which agency?

Have you ever had a license denied by any State/Province? Yes____ No ✓

Reason for denial:

Have you ever been involved in any malpractice matter which resulted in a settlement or judgment against you in excess of $20,000? Yes____ No ✓

Have you ever had hospital privileges revoked; denied; suspended or restricted in any way? Yes____ No ✓

If "Yes", name and address of hospital(s)

(NOTE: Attach separate sheet, if necessary)

I DECLARE UNDER PENALTY OF PERJURY that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this Preliminary Questionnaire, I hereby agree that such shall constitute cause for the denial of my eligibility to apply for licensure as an allopathic physician in the State of Arizona.

SIGNATURE: [signature] **M.D.** **DATE:** 2/8/98

RECEIVED B.O.M.E.X.
FEB 11 98

Remove your new pocket certificate from the receipt portion and carry with you at all times.

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CA 95825-3236
916 263-2571

03/15/97

03/15/97

CUT ON DOTTED LINE

CUT ON DOTTED LINE

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CA 95825-3236
916 263-2571

CUT ON DOTTED LINE

PHYSICIAN AND SURGEON

CERTIFICATE G 41246 EXPIRATION 04/30/99

BARBARA ELLEN ZIPKIN

[redacted]

ORIGINAL ISSUANCE DATE 11/28/79

Signature

PMQG 12/30/94

RECEIPT NO. 04801838

IMPORTANT

1. Please include your certificate no. on any correspondence to this office.
2. Notify the Board of any name or address change in writing.
3. Report any loss immediately in writing to the Board.
4. Please sign and carry the Pocket certificate with you.

BARBARA ELLEN ZIPKIN

CERTIFICATE NO.	EXPIRATION	RECEIPT NO.
G 41246	04/30/99	04801838

This is your RECEIPT. Please save for your records.

The Board of Medical Quality Assurance
OF THE STATE OF CALIFORNIA

This is to Certify, That Barbara Ellen Zipkin, a graduate of Northwestern University Medical School having shown to the satisfaction of this Board that she possesses the qualifications required by law, and having produced a DIPLOMATE CERTIFICATE issued to her by the NATIONAL BOARD OF MEDICAL EXAMINERS OF THE UNITED STATES on the 3rd day of January, 1977, which complies with the requirements of the Business and Professions Code of the State of California, relating to the practice of medicine and surgery, is hereby granted a

Physician's and Surgeon's Certificate

IN THIS STATE

In Testimony Whereof, THE BOARD OF MEDICAL QUALITY ASSURANCE *of the* STATE OF CALIFORNIA *has issued this* CERTIFICATE *and caused the same to be signed by its* PRESIDENT *and* SECRETARY-TREASURER *and its* SEAL *to be hereto affixed this* 26th *day of* November, A.D. 1979.

No. G-41246

The Board of Medical Quality Assurance
OF THE STATE OF CALIFORNIA

[signature]
President

[signature]
Secretary-Treasurer

THE UNIVERSITY OF THE STATE OF NEW YORK

EDUCATION DEPARTMENT

BE IT KNOWN THAT

BARBARA E. ZIPKIN

HAVING GIVEN SATISFACTORY EVIDENCE OF THE COMPLETION OF PROFESSIONAL AND OTHER REQUIREMENTS PRESCRIBED BY LAW IS QUALIFIED TO PRACTICE

MEDICINE AND SURGERY

IN THE STATE OF NEW YORK

IN WITNESS WHEREOF THE EDUCATION DEPARTMENT GRANTS THIS LICENSE UNDER ITS SEAL AT ALBANY, NEW YORK THIS FIRST DAY OF JULY, 1977.

LICENSE NUMBER

131258

Gordon M. Ambach
PRESIDENT OF THE UNIVERSITY AND COMMISSIONER OF EDUCATION

William C Seppel
ASSISTANT EXECUTIVE SECRETARY STATE BOARD FOR MEDICINE

National Board of Medical Examiners

of the

United States of America

Barbara Ellen Zipkin, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a

Diplomate of the National Board of Medical Examiners

Attest John S. Millis
Chairman of the Board

President of the Board

Philadelphia, Pa.
January 3, 1977

Certificate No. 165118

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

Governor

Douglas A. Ducey

Members

Gordi Khera, M.D.
Chair
Physician Member

Richard Perry, M.D.
Vice-Chair
Physician Member

Ram R. Krishna, M.D.
Secretary
Physician Member

Jodi Bain, Esq.
Public Member

Marc Berg, M.D.
Physician Member

Donna Brister
Public Member

R. Screven Farmer, M.D.
Physician Member

Robert E. Fromm, M.D.
Physician Member

Paul S. Gerding, Esq.
Public Member

James Gillard, M.D.
Physician Member

Edward G. Paul, M.D.
Physician Member

Wanda Salter, R.N.
Public Member/R.N.

April 3, 2015

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

Dr. Barbara Zipkin

This will acknowledge receipt of your renewal application for licensure to practice medicine in the State of Arizona. I have reviewed your renewal application. To complete the processing of your renewal application, the following deficient documentation is still required:

1.) **Please provide government issued document that contains a photograph.**

*****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 DEFICIENT ITEMS ARE NOT RECEIVED WITHIN 60 DAYS OF THIS DEFICIENCY NOTICE, YOUR ARIZONA MEDICAL LICENSE WILL EXPIRE ON ITS SCHEDULED EXPIRATION DATE. ANY DEFICIENT ITEMS THAT ARE RECEIVED AFTER THE 60 DAY PERIOD WILL NOT BE ACCEPTED. IF YOUR LICENSE EXPIRES YOU MAY REAPPPLY 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.

Desirae Johnson
Arizona Medical Board
Licensing Assistant
Desirae.Johnson@azmd.gov

AMB - Physician Renewal - Confirmation (Step 8 of 11) 3/4/2016

Barbara Ellen Zipkin

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

No

5) Since your last renewal, have you had hospital privileges revoked, denied, suspended, or restricted? If so, provide an explanation. (Do not report if your hospital privideges were suspended due to failure to complete hospital record and reinstated after no more than 90 days)

No

6) Since your last renewal, Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? If so, provide an explanation.

No

7) Since your last renewal, have you had your authority to prescribe, dispense, or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency as a result of disciplinary or other adverse action? If so, provide an explanation.

No

8) This question has been deleted

9) Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude (in any state) , or an alcohol or drug-related offense in any state? Is so, provide an explanation. See list of Moral Turpitude items at .

No

10) Since your last renewal, have you failed the special purpose licensing examination (SPEX)?

No

Physical/Mental Health and Substance Abuse Questions

1) Since your last renewal, have you received treatment for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narcotic or a physical, mental, emotional, or nervous disorder or condition that currently affects your ability to exercise the judgment and skills of a medical professional? If so, provide the following: A) Detailed description of the use, disorder, or condition; and B) An explanation of whether the use, disorder, or condition is reduced or ameliorated because you receive ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating. C) A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.

The purpose of the confidential question is to allow the Board to determine current fitness to practice medicine. The mere fact of treatment is not, in itself, a basis for denial. The Board often licenses individuals who demonstrate personal responsibility but may limit or deny applicants whose ability to practice is affected by a condition or who demonstrate a lack of candor in their responses. The Board encourages applicants to seek assistance if needed.

Citizenship Status

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

Specialties

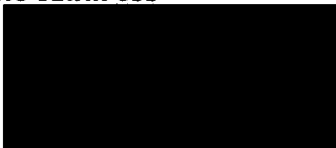
	Specialty	Certified?	Practicing?	Date Certified	Expiration Date
Primary Specialty	Obstetrics & Gynecology	Yes	Yes	12/09/1983	

Practice Address

Camelback Family Planning
4141 W.32nd St.
Phoenix AZ, 85018
Phone: (602) 279-2337
Fax: (602) 230-9025

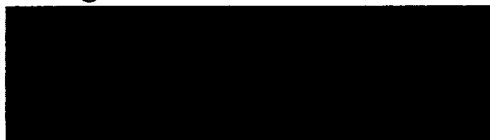
You are required to enter a valid address, if you have one.

Home Address



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

Mailing Address



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.

Arizona Medical Board: License Renewal Questions

Barbara	Zipkin	2013	License # 26425	Professional Conduct

Question	Answer	Explanation
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

Barbara	Zipkin	2013	License # 26425	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.

BIENNIAL MD LICENSE RENEWAL APPLICATION

(Please Type in Spaces Provided)

RECEIVED MAR 08 2011 By

- ☐ License Fee: $500 (If postmarked by due date)
- ☐ $850 if postmarked 30 days after due date

B. Zipkin MD

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.

***REMEMBER:** There is a $25 fee for processing a deficient renewal. Please double check your completed application before mailing.*

First Name: Barbara **Initial:** **Last Name:** Zipkin

License Number:

ADDRESSES:

Office Address: This is the office/principle 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: Please provide a mailing address if different from Office or Home Address. If no address is provided, all Board correspondence will be sent to the Office Address.

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.

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

Practice Name: Barbara Zipkin, MD

Office Address: 4900 Sunset Blvd **City:** LA **State:** Ca **Zip:** 90027

Email: [redacted] **Office Phone:** 800-954-8000 **Office Fax:** 323-783-4736

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

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

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

***PLEASE NOTE:** You are required to notify the Board in writing within 30 days of any change in office or home address and telephone number. A.R.S. §32-1435(B) & (D). There is a fine of $100 for failure to report change of address.*

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 field of practice from the drop down list. If you are Board certified, check "yes." If certified since your last renewal, please attach a copy of the ABMS certificate or letter.

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
Ob-Gyn	☒ Yes ☐ No	☒ Yes ☐ No	Lifetime
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

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. Statement of Citizenship and Alien Status available on the website.

☒ I am a U.S. Citizen or U.S. National. (If you have not provided the Board with a copy of one of the documents listed in the Statement of Citizenship and Alien Status (i.e. birth certificate, passport, etc) since 2008, please submit a copy with your application.

☐ 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 an "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents, such as an Alien Registration Card, Visa, etc.)

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.

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, please submit the CME documentation with your completed renewal.*

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

Question	Yes	No
1. Since your last renewal, have you had any application for any professional license refused or denied by any licensing authority?	☐ Yes	☒ No
2. Since your last renewal, have you been refused or denied the privilege of taking an examination required for any professional licensure?	☐ Yes	☒ No
3. Since your last renewal, have you voluntarily surrendered any healthcare license?	☐ Yes	☒ No
4. Since your last renewal, have you had any healthcare license revoked?	☐ Yes	☒ No
5. 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, license healthcare facility or healthcare staff of such facility?	☐ Yes	☒ No
6. Since your last renewal, have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	☐ Yes	☒ No
7. Since your last renewal, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? "Disciplinary Action" includes, but is not limited to restriction, termination, voluntary or involuntary resignation or withdrawn.	☐ Yes	☒ No
8. Since your last renewal, have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied, or have you surrendered or given up in lieu of action?	☐ Yes	☒ No
9. Since your last renewal, 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
10. Since your last renewal, 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 expunged?	☐ Yes	☒ No
11. Since your last renewal, have you been court martialed or discharged other than honorably from the armed service?	☐ Yes	☒ No
12. Since your last renewal, have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	☐ Yes	☒ No
13. Since your last renewal, have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	☐ Yes	☒ No

NOTE: In the event 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.

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: Barbara Initial: Last Name: Zipkin

License Number:

CONFIDENTIAL QUESTIONNAIRE

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 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.

☑ **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: Barbara **Initial:** **Last Name:** Zipkin

Signature: [signature] **License Number:**

Questions?

CK 1229

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 26425 — **Renewal Fee: $500 ~~$850 if postmarked 30 days after due date~~**

Name: Barbara Zipkin, MD , MD

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

4900 Sunset Blvd.
L.A., Ca. 90027

Phone #: (800) 954-5000 **Fax #:** (323) 783-4736

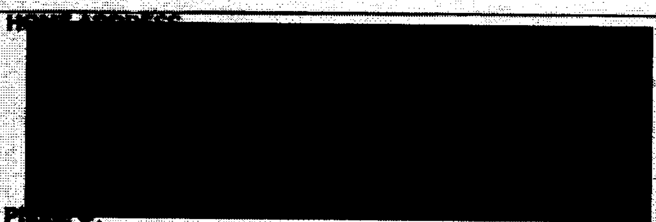
E-Mail:

MAILING ADDRESS

Same

RECEIVED
AUG 03 2009
AZ MEDICAL BOARD

HOME ADDRESS



Phone #:

Mobile #:

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

Field of Practice Code (see attached form for code)	ABMS Certified? (Y/N)	Practicing? (Y/N)	Expiration Date (or indicate lifetime certificated)
OBG	y	y	Lifetime

REQUEST FOR CHANGE IN LICENSE STATUS:

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

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

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

☐ **I am a U.S. Citizen or U.S. National** (If this box is checked please submit with your application a copy of one of the listed approved supporting documents listed in the "Arizona Statement of Citizenship and Alien Status for State Public Benefits" i.e. Birth Certificate, U.S. Passport, etc.)

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

[signature] 7/28/09

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

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

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

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

Name: Barbara Zipkin, MD. License Number: 26425

Signature: [signature] MD

CONFIDENTIAL

rehabilitation program? *If in a confidential program in another state see explanation below.

4.	**Since your last renewal have you been criminally charged with or investigated by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility for inappropriate contact with a patient or patients?**
5.	**Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice?**

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

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

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

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

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

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

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

Name: Barbara Zipkin, MD License Number: 26425

Signature: [signature] MD

ARIZONA MEDICAL BOARD

2007 BIENNIAL MD LICENSE RENEWAL APPLICATION

pd 2519

AZ MD Lic#: 26425 Barbara Zipkin, MD

Renewal Fee: $500 $850 (if postmarked after 05/09/2007)

CURRENT INFORMATION Please review and make corrections as necessary	**CORRECTIONS**
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER 4900 W Sunset Blvd Los Angeles CA 90027-5814	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**
Phone #: (818) 783-7979 **Fax #:**	**Phone #:** 800-954-8000 **Fax #:**
E-Mail:	**E-Mail:**
MAILING ADDRESS [redacted]	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:**	**Phone #:** **Fax #:**
E-Mail:	**E-Mail:**
Mobile #:	**Mobile #:** (Optional)

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MAR 23 2007
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

	Certified?	Practicing?
OBG	Y	Y

Make corrections if necessary INTIALS REQUIRED

	Certified?	Practicing?	Expiration Date	Initials Required

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

REQUEST FOR CHANGE IN LICENSE STATUS:

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

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

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

[signature] 3/6/07

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

26425 Barbara Zipkin, MD

SEE REVERSE SIDE

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

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

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

26425 Barbara Zipkin, MD

INITIALS REQUIRED

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

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

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

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

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

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

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

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

Please note: All documents requested above must be sent directly from the primary source to the Arizona Medical Board's Physician Health Program Department from the primary source and will not be accepted if submitted by the applicant.

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

If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

26425 Barbara Zipkin, MD **INITIALS REQUIRED** BZ

ARIZONA MEDICAL BOARD
2005 BIENNIAL MD LICENSE RENEWAL APPLICATION

2057

AZ MD Lic#: 26425 Barbara Zipkin, MD | **Renewal Fee: $500** | **$850** (if postmarked after 05/09/2005)

CURRENT INFORMATION | CORRECTIONS

Current Information	Corrections
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER**	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** 4900 Sunset Blvd, L.A., Ca 90027
Phone #: (818) 783-7979 **Fax #:**	**Phone #:** **Fax #:**
E-Mail:	**E-Mail:**
MAILING ADDRESS [redacted]	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:**	**Phone #:** **Fax #:**
E-Mail:	**E-Mail:**
	Cell Phone #: (Optional)

RECEIVED MAR 11 2005

AMERICAN BOARD CERTIFICATIONS AND FIELDS OF PRACTICE:

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

	Certified?	Practicing?
OBG	Y	Y

Make corrections if necessary

	Certified?	Practicing?

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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

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

PLEASE ANSWER THE FOLLOWING QUESTIONS:

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

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

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2003 and 2004, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

Signature of licensee (Signature stamp will not be accepted) [signature] Date: 3/8/05

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

ARIZONA MEDICAL BOARD
2003 BIENNIAL MD LICENSE RENEWAL APPLICATION

1673

AZ MD Lic#: 26425 Barbara Zipkin, MD — Renewal Fee: **$450** — **$800** (If postmarked after 05/09/2003)

CURRENT INFORMATION (Please review and make corrections as necessary →)	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS 13730 Mammoth Pl Sherman Oaks CA 91423-6605	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**
Phone #: (818) 790-8304 **Fax #:** **E-Mail:**	**Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS [redacted] IK	**MAILING ADDRESS** MAR 17 2003
HOME ADDRESS [redacted] ER	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** **E-Mail:**	**Phone #:** [redacted] **E-Mail:** **Cell Phone #:** (Optional)

AMERICAN BOARD CERTIFICATIONS AND FIELDS OF PRACTICE:

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

	Certified?	Practicing?
OBG	Y	Y

Make corrections if necessary

	Certified?	Practicing?

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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

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

PLEASE ANSWER THE FOLLOWING QUESTIONS:

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

If the answer is "yes" to any of the above questions, please provide a complete written explanation. If malpractice cases are reported, please include: the case number, venue, plaintiff name, and attorney names/addresses/phone numbers.

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2000 and 2001, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

[signature] ______ 3/10/03 ______

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

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