Arizona State Board of Medical Examiners
9545 East Doubletree Ranch Road, Scottsdale Arizona 85258
Home Page http www.docboard.org
Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

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

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FOR BOARD USE
DO NOT USE THIS SPACE

Date Application Sent AUG 25 2000

Date Application Received _____

☐ ENDORSEMENT
☐ USMLE
☐ SPEX

#12024

BE COMPLETED BY THE APPROPRIATE AGENCY AND RETURNED DIRECTLY TO THIS BOARD

INFORMATION

All candidates shall provide satisfactory evidence that he/she

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

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 Applications not fully complete within one year from date of notification of deficiency in application are considered withdrawn.

APPLICATION INSTRUCTIONS
(Read Carefully)

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

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

UNITED STATES OR CANADIAN MEDICAL S[redacted]OL GRADUATES and GRADUATES OF MEDI[redacted] SCHOOLS LOCATED OUTSIDE THE UNITED STATES OR CANADA will forward the designated fo[redacted]e appropriate agency with the request that they be co[redacted] and returned *direct* to the Arizona Board of Medical Examiners

APPLICATION and Initial Registration

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

1 Present Legal Name REUSS ERIC MICHAEL
(Last) (First) (Middle) (Maiden)

(a) Other names used N/A 480-945-4849

2 Office Address 7331 EAST OSBORNE DR STE 305 SCOTTSDALE 85251
(No) (Street) (City) (State) (Zip/Post Code) (Area 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 JULY 1998 GRANTED A66878
(State Board) (Date of Application) (Result) (Certificate No)

10/30/98 WRITTEN
(Date Issued) (Specify if by Written Examination or on Credentials)

(b) N/A
(State Board) (Date of Application) (Result) (Certificate No)

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

Please answer questions on line at right.

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

6 Has any disciplinary or rehabilitative action ever been taken against you by any state licensing board including other health professions? Examples of actions include but are not limited to reprimand, censure, probation restriction limitation, suspension stipulation written consent agreement or revocation No

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

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

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

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

11 Have you ever had a medical license disciplined resulting in a revocation, suspension, limitation restriction probation voluntarily surrender cancellation during an investigation or entered into a consent agreement or stipulation? No

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

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

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

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

16 Are your currently in engaged in th[redacted]al use of any controlled substance, habit fo[redacted] drug or prescription medication?

17 Have you consumed intoxicating beverages resulting in your present ability to exercise the judgement and skills of a medical professional being impaired or limited?

18 Have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? No

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

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

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

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

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

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

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

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

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

21 Name and location of Medical School TULANE UNIVERSITY SCHOOL OF MEDICINE
1430 TULANE AVENUE NEW ORLEANS, LA 90112

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

INTERNSHIP 1997 - 1998 DEPT OF REPRODUCTIVE MEDICINE
RESIDENCY 7/98 - PRESENT UNIV OF CALIFORNIA, SAN DIEGO MEDICAL CENTER
200 W ARBOR DRIVE SAN DIEGO, CA 92103

23 Are you certified by any of the American Board of Medical Specialties? NO

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

At SAN DIEGO (City) CALIFORNIA (State) from 7/1997 to PRESENT
At (City) (State) from to
At (City) (State) from to
At (City) (State) from to

The applicant ERIC M REUSS

(PRINT OR TYPE YOUR NAME AS YOU WISH IT TO APPEAR ON YOUR MEDICAL LICENSE)

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

Signature of Applicant E M Re, M.D

STATE OF CALIFORNIA

County of SAN DIEGO

NELITA S. DIMAGIBA
COMM. #1265789
NOTARY PUBLIC • CALIFORNIA
SAN DIEGO COUNTY
Commission Expires June 9, 2004

(NOTARY SEAL)

Subscribed and sworn to before me this 11th day of December 20 00

Notary Signature Nelita S. Dimagiba My Comission expires June 9, 2004

(NOTARY PUBLIC)

FOR OFFICIAL USE ONLY

Application Processed by MA 1/30/01

Application Checked by [illegible]

Application Approved 2/27 20 01 By Gordon A Medcoff, Exec Mgr

License Issued 3-9-01

License Number 29095

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

Form 1
Hospital Affiliation/Medical Employment Listing

INSTRUCTIONS:
1. Please type or print legibly
2. List all hospital affiliations for the past five (5) years to include moonlighting and courtesy staff affiliations ***Do not*** include postgraduate training.
3. List all employment with medical employment, i e. physician placement group, emergency medical group, radiology group, etc

Applicant Name ERIC MICHAEL REUSS

1 Hospital ALL HOSPITALS ARE RESIDENCY ASSOCIATED

Address _____
Street City State Zip/Post Code

Dates of Staff Membership _____

Type/Category of Staff Membership _____

2 Hospital _____

Address _____
Street City State Zip/Post Code

Dates of Staff Membership _____

Type/Category of Staff Membership _____

3 Hospital _____

Address _____
Street City State Zip/Post Code

Dates of Staff Membership _____

Type/Category of Staff Membership _____

4 Medical Employment _____

Address. _____
Street City State Zip/Post Code

Dates of Employment: _____

5 Medical Employment _____

Address _____
Street City State Zip/Post Code

Dates of Employment _____

Reuss, Eric

RECEIVED JAN -8 01

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

Form 2
Medical College Certification

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

Name ERIC MICHAEL REUSS, M D

Eric Michael Reuss 12/15/00
Signature Date (Month/Day/Year)

(DO NOT DETACH)

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

This is to certify that ERIC MICHAEL REUSS
(Full name of student)

was granted the degree of DOCTOR OF MEDICINE

by TULANE UNIVERSITY SCHOOL OF MEDICINE on 5/31/1997
(Full name of School or College of Medicine as it appears on the Applicant's Medical degree diploma) Date (Month/Day/Year)

that the date of his/her matriculation in medical school was 8/17/93, and that he/she attended all (number) full courses of medical lectures comprising 9 (number) months each.

1 Was applicant ever placed on probation, restricted, or limited? NO If yes, please attach written explanation

2 Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? [redacted]

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

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

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

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

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

3 Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation

4 Were applicant's final evaluations in every category rated satisfactory and/or above? Yes ✓ No _____ If no please attach written explanation

Signed Edward Foulks, M.D. M D (Seal of College)
Edward Foulks, M.D.

Dean / President / Secretary / Registrar } of Tulane University School of Medicine Date January 4 (Month/Day), 20 01

Address 1430 Tulane Ave., New Orleans, LA 70112

12/20

RECEIVED FEB-6 01

Arizona Board of Medical Examiners
P.O. Box 6200
Scottsdale, Arizona 85261-6200
Phone 480-551-2700 Fax 480-551-2704
http //www bomex org

Form 3
Postgraduate Training Certification

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved postgraduate training program in the United States or Canada This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECT** to the Arizona State Board of Medical Examiners, P O. Box 6200, Scottsdale, Arizona 85261-6200 Your prompt response will be appreciated.

Name: ERIC M REUSS SSN 526-93-6867, M.D.

Eric M Reuss MD 2/1/01
Signature Date (Month/Day/Year)

(DO NOT DETACH)

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

This is to certify that Eric M Reuss, M.D. undertook and satisfactorily completed a full term approved program of 48 (number) months in the University of California, San Diego Medical Center, 200 West Arbor Drive, San Diego, 92103-8434 (Full name and complete address of Hospital)

in the field of Obstetrics + Gynecology (Reproductive Medicine) from 6-24-97 (Date) (Mo/Day/Yr) to 6-30-2001 (Date/Anticipated Date)

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

1 Was applicant ever placed on probation, restricted, or limited? no If yes, please attach written explanation

2 Was there any reason not to continue applicant in the training program? Yes ____ No no

3 Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? [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

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

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

3. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? [redacted] If yes, please attach written explanation.

4 Were applicant's final evaluations in every category rated satisfactory and/or above? Yes ✓ No ____ If no please attach written explanation

Signed Charles Nager, M.D. MD (Seal of Hospital)
Title Professor + Program Director
Address: 200 West Arbor Drive
Date 2/1/01

THE UNIVERSITY OF CALIFORNIA UC MEDICAL CENTER SAN DIEGO

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San Diego, CA 92103-8434

US·MLE
United States
Medical
Licensing
Examination™

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

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 01/11/2001

Arizona Board of Medical Examiners
ATTN. Claudia Foutz
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258

Examinee: Reuss, Eric Michael
USMLE ID#: 4-053-510-6
DOB: [redacted]
Alt Name(s):

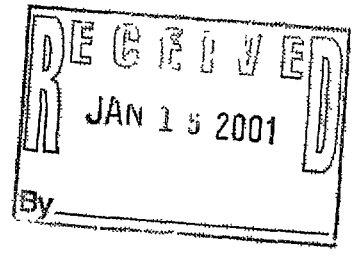
Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	6/14/1995	PASS	223	(176)	88	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	8/27/1996	PASS	236	(170)	90	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
CALIFORNIA	5/12/1998	PASS	215	(177)	86	(75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.



See reverse side for explanation of information reported above.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

SATISFACTION OF REQUIREMENTS SUMMARY

12/20/00

Applicant:	Reuss, Eric Michael
Birthplace:	[redacted]
Medical Education	**From** Tulane University School of Medicine **in** New Orleans, Louisiana **Degree Date:** 05/31/1997
Postgraduate Training	**In:** Obstetrics & Gynecology **for** 45 **months at** UCSD MEDICAL CENTER **From** 06/24/1997 **to** 02/28/2001
Clinical	
Boards	**Of** Obstetrics & Gynecology **taken on** — Educational Requirements Not Met Is not a diplomate
Written Examinations	
Endorsement	USMLE Step III **taken on** 05/12/1998 **in** California
SPEX	
Licenses	AMA **received on** 01/16/2001 — **Info** N/D California **received on** 12/26/2000 — **Status** Current — **Info** N/D FSMB **received on** 12/29/2000 — **Info** N/D NPDB **received on** 01/05/2001 — **Info** N/D
	ma 1/30/01 BR 2/27/01

Arizona State Board of Medical Examiners
P O Box 6200 – Scottsdale AZ 85261-6200
Home Page www bomex org

Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

February 27, 2001

Eric M. Reuss, MD
[redacted]

Dear Dr. Reuss

The Arizona State Board of Medical Examiners is pleased to inform you that your application for licensure in the State of Arizona has been approved Your license will be issued upon receipt of the required statutory license registration fee A R S 32-1436(A)(2) and is renewable on your birthday, [redacted]

The legislation enacting the initial licensing fee was signed into law in April 2000 and implemented by the Board effective September 1, 2000 As of January 1, 2001 Arizona converted to biennial licensure based on birth month and odd or even birth year Your required license registration fee is $356 25. Please complete the bottom portion of this letter and return the completed form with the initial license registration fee in the enclosed envelope Note, the residential address and phone number are not available to the public unless they are the only address and number of record. You are not permitted to commence the practice of medicine in the State of Arizona until your license has been issued.

If you have any questions, please contact me by e-mail at MSlaughter@bomex org or by telephone at (480) 551-2756.

Sincerely,

Marie Slaughter
Licensing and Renewal Administrator

(DO NOT DETACH)

Name Eric Michael Reuss, M.D.

Office Address 7331 E. Osborn Dr., Suite 305 Scottsdale, AZ 85251

Home Address [redacted]

Mailing Address: 7331 E. Osborn Dr., Suite 305 Scottsdale, AZ 85251

Office Telephone Number: (480) 945-4849 Home Telephone Number: [redacted]

Field of Practice Obstetrics and Gynecology

cc File

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Examination
TM

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

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 01/11/2001

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ATTN: Claudia Foutz
9545 East Doubletree Ranch Road
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Examinee: Reuss, Eric Michael
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Alt Name(s):

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

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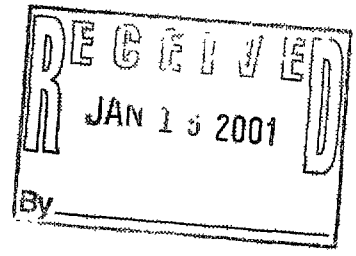

See reverse side for explanation of information reported above.

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination (USMLE) scores is printed on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The embossed USMLE seal in the lower left corner certifies the authenticity of this document Alteration or forgery of a USMLE Transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

TO TEST FOR AUTHENTICITY When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES

USMLE Transcripts 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 each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first-time examinees from medical schools in the United States was 200 and 20, respectively 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 the recommended 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 USMLE Step 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 7 score points on the three-digit scale and 1 to 2 score points on the two-digit scale

ANNOTATIONS APPEARING UNDER "COMMENTS"

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

Indeterminate - Results 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, unexplained inconsistency of performance within the examination or between administrations of the same Step **No score is reported.**

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

Irregular Behavior - The 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 and the determination of the Committee, contact 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

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

ANNOTATIONS APPEARING AS "NOTE"

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

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

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

Home Address and Telephone Number Application Supplement
(Confidential Information)

PLEASE READ CAREFULLY

Arizona Revised Statute (A.R.S.) §32-145(B) requires the licensee to provide the Arizona Board of Medical Examiners (BOMEX) with a current address and telephone number. Additionally, A.R.S. § 32-3801 mandates that BOMEX not provide access to a physician's home address and telephone number unless these are the only address and telephone number of record.

To assist BOMEX in complying with both statutes, this supplemental form for residence address and telephone number is provided. Please ***do not*** indicate your home address and telephone number on any other application forms for licensure.

Please type or legibly print the following information:

ERIC M. REUSS
Name

[redacted]
Street Address

[redacted]
City, State, Zip or Postal Code, Country

[redacted]
Home phone number (including area code, country and city code)

[redacted]

Office email address — Home email address

Office website

This address and telephone phone number will remain confidential ***unless it is the only address and telephone number of record.***

Arizona State Board of Medical Examiners
9545 East Doubletree Ranch Road0 • Scottsdale, Arizona
85258
Home Page: www.bomes.org
Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

March 28, 2001

Eric Reuss, MD

Dear Dr. Reuss:

Congratulations! Your license # 29095 to practice medicine in the State of Arizona was issued March 9th, and your certificate and wallet registration card are enclosed.

Enclosed is a copy of the Arizona State Medical Board's Professional Directory and Resource Handbook. It is suggested that you familiarize yourself with the provisions of the Handbook prior to establishing your practice in Arizona.

ARS §321435 states that each person holding a current license to practice medicine in Arizona shall promptly and in writing inform the Board of their current residence, office address and telephone number and of each change in residence and office address or telephone number. In addition the Board may assess the cost of locating a licensee and a penalty of not to exceed one hundred dollars against a licensee who fails to comply with these provisions within thirty days from the date of change.

Please contact Marie Slaughter, Licensing and Renewals Administrator, at (480) 551-2756, if you have any questions.

Sincerely,

Claudia Foutz

Claudia Foutz
Executive Director

Enclosures: Receipt

cc: File

Arizona State Board of Medical Examiners
9545 E Doubletree Ranch Road, Scottsdale, AZ 85258
Home Page http //www bomex org
Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

DEFICIENCY NOTICE
(R4-16-104)

January 30, 2001

Eric Michael Reuss, M.D.

Dear Dr. Reuss

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

Enclosed please find receipt #102785 covering statutory fee of $500.00.

Licensing staff has reviewed your application and determined that it is deficient To complete the processing of your application the Board requires the following information and/or documentation

(1) **Postgraduate Training Certification from University of California, San Diego Medical Center for period July 1, 1997 to anticipated date of completion.** 2·6·01

Please be advised final action cannot be taken until the required information is in your application file It is your responsibility to ensure that the Board receives all documentation

Further, please be advised that if your application is not fully complete within one year from this date, including participation in written SPEX/USMLE Examination (if applicable), your application is deemed withdrawn

When your application is approved, you will be notified of the initial licensing fee due for issuance of your license.

If you have questions, please contact Michelle Adams at e-mail madams@BOMEX.Org or (480) 551-2759.

Sincerely,

Marie Slaughter

Marie Slaughter
Licensing and Renewals Administrator

Enclosures
cc: file

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

Form 5
Federation of State Medical Boards
Data Bank Report

Applicant is to complete this form and forward the completed 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.

Type or legibly print the following information

Name. REUSS (Last) ERIC, (First) MICHAEL (Middle)

Birth Date (Month/Day/Year): [redacted]

Medical School of Graduation and Branch Location: TULANE UNIVERSITY NEW ORLEANS, LA

Date of Graduation (Month/Day/Year): MAY 31, 1997

Physician (applicant's) Signature: Eric Michael Reuss MD

Date signed (Month/Day/Year): 12/15/00

Federation of State Medical Boards Comments:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

DEC 2 2 2000

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

FSMB, Please return this competed form directly to the Arizona State Board of Medical Examiners, 9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258. Thank you.

RECEIVED B.O.M.E.X.
DEC 29 00

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
Licensing Program
1426 Howe Avenue #56
Sacramento, CA 95825
(916) 263-2360
www.medbd.ca.gov

December 21, 2000

Arizona State Board of Medical Examiners
9545 East Doubletree Ranch Rd
Scottsdale, AZ 85258

TO WHOM IT MAY CONCERN:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

PHYSICIAN:	ERIC M. REUSS
LICENSE NUMBER:	A66878
ISSUED:	10/30/98
EXAM TYPE:	a written examination
EXPIRATION DATE:	10/31/02
STATUS:	Renewed/Current

This certification is the only information provided by this office. If additional information is needed, it must be obtained directly from the individual, agency or institution which initially generated the information. To expedite the certification process, this is the standard format prepared for all professions regulated by the Medical Board of California.

If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

Kim Marquardt

KIM MARQUARDT, Manager
Licensing Operations

SEAL

HP 12/20

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

Application Checklist

The following items must be submitted to administratively complete your application The Arizona Board of Medical Examiners (BOMEX) conducts primary source verification of education, training, hospital affiliations, and employment, therefore, verification documents must be mailed ***directly*** to BOMEX from these entities All documentation is to be sent to the Arizona Board of Medical Examiners, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258
Please note: The application cannot be approved until ***ALL*** documentation has been received from the applicant and the primary source verifying entities

PLEASE RETURN THIS CHECKLIST WITH YOUR APPLICATION

Applicant's Name: ERIC MICHAEL REUSS

Copy of one of the following documents.
- ☐ Certified copy of Birth Certificate
- ☒ Passport
- ☐ Baptismal Certificate
- ☐ Alien Registration Card
- ☐ Naturalization Certificate

Copy of either of the following name change documents, if applicable:
- ☐ Marriage License
- ☐ Official Name Change through the Court

The following items are to be completed and enclosed with the application.
- ☒ Arizona Allopathic (MD) License Application
  - ☒ Home Address and Phone Number Supplement (confidential information)
  - ☒ Social Security Number Supplement (confidential information)
- ☒ Cashier's Check or Money Order (**personal checks not accepted**) for application processing fee in the amount of **$500 (US dollars only)** Applications submitted without the fee will not be processed, Pursuant to Arizona Revised Statute § 32-1436(A) the processing fee is nonrefundable
- N/A ☒ **Form 1** Complete List of All Hospital and/or Employment for the Past Five (5) Years

The following enclosed forms are to be forwarded to the appropriate entity for completion.
(When completed by the entity, these are to be sent directly to the AZ Board of Medical Examiners)
- ☐ **Form 2** Medical College Certification
- ☐ **Form 3** Postgraduate Training Certification
- ☐ **Form 4** Verification of licensure from every state in which you currently hold or have ever held licensure
- ☐ **Form 5** Federation of State Medical Boards (FSMB) Disciplinary Search
- ☐ **Form 6** Verification of ***all*** hospital affiliations and employment for the past five (5) years

The following required information is available at the indicated website.
- ☐ AMA Physician Profile (order on line at http //www ama-assn org) (confidential information)
- ☐ Examination and Board Action History Report (EBAHR) to obtain scores ***only*** for
  ☒ **USMLE** ☐ **FLEX** ☐ **SPEX** (2 page form available at http //www fsmb org/form pdf)
- ☐ Endorsement of NBME certification (form available on line at http //www nbme org/new version/cert form htm) or call the Examinee Records Office at 215-590-9592
- ☐ NPDB report (order on line at http //www npdb-hipdb com then click on Query and Report to the Database)

The following information is to be provided *only if applicable.*
- N/A ☐ **Form 7** Clinical Instructor Certification
- N/A ☐ **Form 8** ECFMG Certification (***Required for International Medical School Graduates, only***)
- N/A ☐ Verification of ABMS Certification if applying through Endorsement and current ABMS certification
- N/A ☐ Verification of LMCC or specific State written exam score

To facilitate the timely processing of all applications, please allow 30 days after receipt of your application before calling for a status regarding issuance of your license.

Status of your license will only be provided personally to the applicant or to one representative The applicant must designate the representative in writing.

DEC 20 '00 RCVD

DEC 20 '00 RCVD

Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov

December 21, 2015

Eric Michael Reuss M.D.
7331 E Osborn Dr Ste 305
Scottsdale, AZ 85251-6422

Re: Eric Michael Reuss MD
Case # MD-15-0579C

Dear Dr. Reuss:

You were previously provided notice that a complaint had been filed against your Arizona medical license. The Board's staff has reviewed the complaint, any response(s) you have filed regarding the complaint, and all relevant investigative findings. After reviewing all relevant information, the Board's staff has determined that the complaint does not establish a violation of the Arizona Medical Practice Act. Therefore, as required by Rule 4-16-507, I have dismissed the complaint and notified the complainant of that dismissal.

By law, the complainant may appeal this dismissal if they file their request within 35 days of the notification and they provide the required information. If the investigation is reinstated or reopened by the Board for any reason, you will be notified.

We appreciate your cooperation and patience during this process. Good luck in your medical practice.

Sincerely,

Patricia E. McSorley
Executive Director

Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov • E-Mail: questions@azmd.gov

July 13, 2009

Eric Michael Reuss, M.D.
7331 E Osborn Dr Ste 305
Scottsdale, AZ 85251-6422

Re: Eric Michael Reuss, M.D.
Case # MD-09-0649A

Dear Dr. Reuss:

The Arizona Medical Board has thoroughly investigated this case and found no violation of the Medical Practice Act. Therefore, this case has been dismissed.

The complainant may appeal this dismissal within 35 days of the date of this letter. If this should occur, you will be notified by mail.

Sincerely,

Lisa S. Wynn
Executive Director

LSW/cjp

Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov • E-Mail: questions@azmd.gov

May 21, 2008

Eric Michael Reuss, MD
7331 E Osborn Dr Ste 305
Scottsdale, AZ 85251-6422

RE: Eric Michael Reuss, MD
Case # MD-07-1066C

Dear Dr. Reuss:

The Arizona Medical Board has thoroughly investigated this case and found no violation of the Medical Practice Act. Therefore, this case has been dismissed.

Sincerely,

Lisa S. Wynn
Executive Director

LSW/cjs

Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Fax: 480-551-2704
Website: www.azmd.gov

September 30, 2016

Eric Michael Reuss, MD
7331 E Osborn Dr Ste 305
Scottsdale, AZ 85251

Email Address: [redacted]

**Sent by Email, US First Class Mail

Dear Dr. Eric Michael Reuss:

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

To complete the processing of your renewal application, the following documentation is required.

1. **Government Issued Photo Identification**
   A copy of a government issued photo ID is required if the Board does not currently have a legible copy on file. (i.e.: passport, driver's license)
   Please do not fax photos; scanned copies may be emailed or mailed.

*Please Note: if the above items are not received within 60 days of this notice, your Arizona Medical License will expire **on its scheduled expiration DATE**. Any items that are received after the 60 days will not be **accepted.** If your license expires, you may reapply as an Initial Applicant.

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

A.R.S. § 32-1430:
Except as provided in section 32-4301, each person holding an active license to practice medicine in this state shall renew the license every other year on or before the licensee's birthday and shall pay the fee required by this article, accompanied by a completed renewal form. A licensee who does not renew an active license as required by this subsection on or before thirty days after the licensee's birthday must also pay a penalty fee as required by this article for late renewal. A licensee's license automatically expires if the licensee does not renew an active license within four months after the licensee's birthday. A person who practices medicine in this state after that person's active license has expired is in violation of this chapter.

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.

R4-16-206 Time-frames for License, Permit, or Registration

E. If a licensee does not apply for license renewal according to the biennial renewal requirement, the licensee's license expires according to provisions prescribed under A.R.S § 32-1430 (A) unless the licensee is under investigation according to provisions under A.R.S. § 32-3202. If a licensee makes timely application according to the biennial renewal requirement but fails to respond timely to a deficiency notice under subsection (B) (1) or a request for additional information under subsection (C) (2) and fails to request from the Executive Director an extension of time to respond, the licensee's license expires according to provisions prescribed under A.R.S § 32-1430 (A).

Thank you for submitting an application to practice medicine in Arizona. Please contact our office with any questions.

Sincerely,

Laura Cañez
Licensing Assistant
Laura.Canez@azmd.gov
Arizona Medical Board

From: [redacted]
To: Laura Canez
Subject: Eric Reuss, MD License #29095
Date: Friday, September 30, 2016 3:32:03 PM
Attachments: 2016-09-30 15-24.pdf
ATT00002.txt

Government issued photo identification attached
--
Sent with Genius Scan for iOS.
[redacted]

CC

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

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

RECEIVED
SEP 20 2016
ARIZONA MEDICAL BOARD

Revised 12/15/2015

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

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

☐ **License Fee $850 (if postmarked 31 days after due date)**

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

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

1. **First Name:** ERIC **Initial:** M **Last Name:** REUSS

License Number: 29095

ADDRESS INFORMATION

Practice Address: This is the practice/principal place of your business. The address and phone number provided will appear in the Medical Directory and on the Board's website. **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 upon request. If you want your home address to be listed as your practice address on the Board's website, include the address in the practice address field.

2. **Practice/Training Name:** SCOTTSDALE OBSTETRICS & GYNECOLOGY, P.C.

Address: 7331 E OSBORN DR SUITE # 305 **City:** SCOTTSDALE **State:** AZ **Zip:** 85251

Phone: 4809454849 **Fax:** 4809450989 ***Practice address not required for licensure**

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

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

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

Primary Email Address [redacted]

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

4. **Mailing Address:** **City:** **State:** **Zip:**

☒ Same as Practice Address ☐ Same as Home Address

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

Please note: If a substantive review/investigation is required during the application process, the applicant will be required to provide additional authorization, in writing, for the third party to receive status updates concerning the substantive review.

Name _____ Phone# _____ E-mail _____

5. AREA OF INTEREST/ABMS CERTIFICATION

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

Area of Interest	Practicing?	ABMS Certified?	Expiration Date (Or indicate if lifetime certificate)
Obstetrics & Gynecology	☑ Yes ☐ No	☑ Yes ☐ No	12/31/2016
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

6. CITIZENSHIP ATTESTATION

PROOF OF CITIZENSHIP: All applicants must provide evidence that the applicant is lawfully present in the United States.

A.R.S. 41-1080 and A.A.C. R4-16-201(C)(1) require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona.

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

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

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

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

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

☐ I am not a U.S. Citizen or U.S. National.

First Name: ERIC **Last Name:** REUSS

7. PROTOCOL FOR STORAGE, TRANSFER AND ACCESS OF PATIENT MEDICAL RECORDS

☒ I am aware that it is unprofessional conduct to fail to have a written protocol in place for the secure storage, transfer and access of patient medical records when a physician terminates or sells his/her practice and the medical records do not remain in the same physical location. I have a protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close, as required by A.R.S. §32-3211.

☐ I am exempt from the records protocol requirement as outlined in A.R.S. 32-3211(G). I am a health professional who is employed by a health care institution as defined in Section A.R.S. 36-401 that is responsible for the maintenance of the medical records.

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

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

8. CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

☒ I have completed a minimum of 40 hours CME during the two previous calendar years of renewal year as required by A.R.S. § 32-1434 and A.A.C. § R4-16-101.
**Please do not submit proof of CME unless you received notice on your renewal that you are subject to a CME audit.*
If an audit was indicated, submit CME documentation with your completed renewal.

9. REQUEST FOR CHANGE IN LICENSE STATUS

☐ **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.

10. Training Unit Attestation

Renewal Applications - A.R.S. §32-1422(A)(10): Complete a training unit as prescribed by the board relating to the requirements of this chapter and board rules. The applicant shall submit proof with the application form of having completed the training unit.

I am aware that I am responsible for knowing and adhering to the laws governing the practice of medicine in Arizona. I declare under penalty of perjury that I have read and completed all four pages of the training unit provided with this application and available on the Board's website.

Revised 10/15/2015

Full Name (print): ERIC MICHAEL REUSS **Signature:**

License number: 29095 **Date:** 09/07/2016

11. Questionnaire

1. Since your last renewal, have you had an application for medical licensure denied or rejected by another state or province licensing board?	☐ Yes	☒ No
2. Since your last renewal, have you had any disciplinary or rehabilitative action taken against you by another licensing board, including other health professions?	☐ Yes	☒ No
3. Since your last renewal, have you had any disciplinary actions, restrictions or limitations taken against you while participating in any program or by any health care provider?	☐ Yes	☒ No
4. Since your last renewal, have you ever had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation during an investigation, or entered into a consent agreement or stipulation?	☐ Yes	☒ No
5. Since your last renewal, have you had hospital privileges revoked, denied, suspended, or restricted? (do not report if your hospital privileges were suspended due to failure to complete hospital record and reinstated after no more than 90 days)	☐ Yes	☒ 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 an agency of the federal or state government?	☐ Yes	☒ No
7. 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 as a result of disciplinary or other adverse action?	☐ Yes	☒ No
8. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, a misdemeanor involving moral turpitude, or an alcohol or drug-related offense in any state?	[redacted]	
9. Since your last renewal, have you failed the special purpose licensing examination (SPEX)?	☐ Yes	☒ No

12. Confidential 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.) 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.

[redacted]

NOTE: In the event that the response to any of the questions is "Yes", you must file an explanation and submit photocopies of any corresponding documents. Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

Moral Turpitude includes but is not limited to: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Embezzlement, 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, Theft and Soliciting Prostitution.

First Name: ERIC **Last Name:** REUSS

13. [redacted] Attestation

I attest that all of the information contained in the renewal application and accompanying evidence or other credentials submitted are true. This includes any corrections made to the enclosed physician profile, and any information provided on or submitted with the CME Audit Form.

First Name: ERIC **Last Name:** REUSS

Signature of Applicant: ERIC MICHAEL REUSS Date: 09/07/2016

14. Controlled Substances Prescription Monitoring Program Registration

State law, specifically, Arizona Revised Statutes § 36-2606, requires every Arizona medical practitioner who possesses a Drug Enforcement Administration ("DEA") permit to also hold a Controlled Substances Prescription Monitoring Program ("CSPMP") registration issued by the Arizona State Board of Pharmacy ("Pharmacy Board"). The failure of a medical practitioner to obtain a CSPMP registration may result in disciplinary action by the practitioner's licensing board. See A.R.S. § 36-2607.

Arizona Revised Statutes § 32-3219, mandates the Arizona Medical Board ("Board") to notify the Pharmacy Board of newly licensed physicians who intend to apply for a DEA permit and physicians who renew their licenses. The Board is also required to submit to the Pharmacy Board information to assist the Pharmacy Board in the registration of medical professionals for the CSPMP. To facilitate the Board's collection of this information please complete the enclosed form and submit it to the Board along with your license application/renewal application.

If you have any questions regarding the attached form, please contact Dean Wright at 602-771-2744.

THIS FORM MUST BE RETURNED TO THE ARIZONA MEDICAL BOARD IN ORDER TO COMPLETE YOUR APPLICATION. YOU MUST ALSO SUBMIT THE ATTACHED APPLICATION FOR THE CSPMP REGISTRATION IF YOU INTEND TO APPLY FOR A DEA REGISTRATION OR IF YOU CURRENTLY HAVE A DEA PERMIT.

1. Do you currently have an Arizona DEA permit?	☑ Yes ☐ No
2. Are you registered with the CSPMP?	☑ Yes ☐ No

First Name: ERIC **Last Name:** REUSS

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

10/3/2014

Eric Michael Reuss

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

General Questions

Note: ***In the event the response to any of the questions numbered 1 through 10 is â€œYESâ€***, you must file by fax or mail a detailed report concerning the below matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. IN ADDITION, you must submit photocopies of any corresponding documents, such as complaints or board actions.

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

No

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

No

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

No

4) Since 2009, have you had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation, during an investigation or entered into a consent agreement or stipulation? If so, provide an explanation.

No

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

No

6) Since 2009, Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? If so, provide an explanation.

No

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

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

No

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

[redacted]

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

No

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

No

Physical/Mental Health and Substance Abuse Questions

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

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

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

[redacted]

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

[redacted]

Citizenship Status

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

Specialties

	Specialty	Certified?	Practicing?	Date Certified	Expiration Date
Primary Specialty	Obstetrics & Gynecology	Yes	Yes		

Practice Address

(Directory Address)
Scottsdale OB/GYN PC
7331 E Osborn Dr Ste 305
Scottsdale AZ, 85251-6422
Phone: (480) 945-4849
Fax: (480) 945-0989

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

Home Address

[redacted]

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

Mailing Address

Scottsdale Ob/gyn Pc
7331 E Osborn Dr Ste 305
Scottsdale AZ, 85251-6422
[redacted]

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

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

By agreeing with this data, you are signing this registration form and certifying under pentalty of perjury that all information on this form is currently accurate and:

· I am a U.S. Citizen or a qualified/registered alien

· I have completed a minimum of 40 credit hours of continuing medical education during the two calendar years preceding renewal year as required by A.R.S. Â§32-1434 and A.A.C. Â§ R4-16-101

· I have a written protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close as required by A.R.S. Â§32-3211.

I Agree ○ **Yes** ◉ **No**

MD Training Unit

Complete

You may wish to print this Page for your records.

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

Back Next

Arizona Medical Board: License Renewal Questions

Eric Reuss 2012 License # 29095 Professional Conduct

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

Arizona Medical Board: License Renewal Questions

Eric	Reuss	2012	License # 29095	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.

[redacted]

BIENNIAL MD LICENSE RENEWAL APPLICATION

(Please Type in Spaces Provided)

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

☐ **$850** if postmarked 30 days after due date

RECEIVED
SEP 21 2010
AZ MEDICAL BOARD

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: Eric **Initial:** M **Last Name:** Reuss

License Number: 29095

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: Scottsdale OB-GYN P.C.

Office Address: 7331 E Osborn Dr #305 **City:** Scottsdale **State:** AZ **Zip:** 85251

Email: [redacted] **Office Phone:** 4809454849 **Office Fax:** 4809450989

Mailing Address: 7331 E Osborn Dr #305 **City:** Scottsdale **State:** AZ **Zip:** 85251

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

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

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	DEC 31, 2010
	☐ 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

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: ERIC **Initial:** M **Last Name:** REUSS

License Number: 29095

CONFIDENTIAL QUESTIONNAIRE

[redacted]

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: ERIC **Initial:** M **Last Name:** REUSS

Signature: E Reuss MD **License Number:** 29095

Questions?

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 29095 Renewal Fee: $500 $850 (if postmarked 30 days after due date

Name: Eric Reuss, MD

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

7331 E. osborn dr #305
Scottsdale AZ 85251

Phone #: 480.945.4849 Fax #: 480.945.0989

E-Mail: [redacted]

MAILING ADDRESS

7331 E. osborn dr #305
Scottsdale AZ 85251

SEP 29 2008

HOME ADDRESS

[redacted]

SEP 30 2008

Phone # [redacted]

Mobile # [redacted]

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

Field of Practice Code (see attached form for code)	ABMS Certified? (Y/N)	Practicing? (Y/N)	Expiration Date (or indicate lifetime certificate
OBG	yes	yes	Dec-31, 2009

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 an

- 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 shou 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 th listed approved supporting documents listed in the "Arizona Statement of Citizenship and Alien Status for State Publ 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 yo 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

SEP 30 2008

ENTERED

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.

Name: _____ License Number: 29095

Signature:

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.

[redacted]

In the event you answer YES to any of the above questions, you must file with the renewal a detailed writte narrative statement concerning the above matter(s), including the name and address of healthcare providers, physician preceptors, hospitals/rehabilitation centers, etc. where you were counseled/treated. You must also have a copy of yo history and physical examinations, consultation reports, discharge summaries from all hospitals/rehabilitation centers and statement from your attending physicians or treating therapists setting forth your diagnosis, prognosis and recommendatio for continuing care, treatment, supervision and a statement as to whether there is anything that would prevent you fro safely practicing any type of medicine. **Statement from attending physician must come with your renewa** 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 f the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues YOU MUS SUBMIT A NARRATIVE OF CIRCUMSTANCES WITH YOUR RENEWAL AND REQUEST THE FOLLOWING DOCUMENTATION E 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 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 CA 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: _____ License Number: 29095

ARIZONA MEDICAL BOARD
2006 BIENNIAL MD LICENSE RENEWAL APPLICATION

CK 18071

AZ MD Lic#: 29095 Eric M. Reuss, MD **Renewal Fee: $500 $850** (if postmarked after **11/21/2006**)

CURRENT INFORMATION Please review and make corrections as necessary™	CORRECTIONS
OFFICE ADDRESS/ PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER 7331 E Osborn Dr Ste 305 Scottsdale AZ 85251-6422	**OFFICE ADDRESS/ PRINCIPAL PLACE OF BUSINESS**
Phone #: (480) 945-4849 **Fax #:** (480) 945-0989	**Phone #:** **Fax #:**
E-Mail:	**E-Mail:**
MAILING ADDRESS 7331 E Osborn Dr Ste 305 Scottsdale AZ 85251-6422	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** **E-Mail:** [redacted] **Mobile #:**	**Phone #:** **Fax #:** **E-Mail:** **Mobile #:** (Optional)

RECEIVED BY:
SEP 5 2006
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

	Certified?	Practicing?
OBG	Y	Y

Make corrections if necessary INTIALS REQUIRED

	Certified?	Practicing?	Expiration Date	Initials Required
OBG	Y	Y VERIFIED Licensing	12/31/2009	D

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

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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

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

CONTINUED ON BACK →

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES ☐ NO ☑
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐ NO ☑
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES ☐ NO ☑
4. Since your last renewal have you had any healthcare license revoked?	YES ☐ NO ☑
5. Other than Arizona have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐ NO ☑
6. Since your last renewal have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐ NO ☑
7. Other than Arizona has disciplinary action been taken against you by any licensing agency with regard to any professional license? Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.	YES ☐ NO ☑
8. Since your last renewal have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action? SEP 8 2006	YES ☐ NO ☑
9. Since your last renewal have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) A "yes" answer is required even if you entered a diversion program.	YES ☐ NO ☑
10. Since your last renewal have you been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES ☐ NO ☑
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	YES ☐ NO ☑
12. Since your last renewal have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐ NO ☑
13. Since your last renewal have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	YES ☐ NO ☑

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

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

QUESTIONS CONTINUED ON NEXT PAGE →

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

[redacted]

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?** See below for definition of ability to practice medicine.

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

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

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

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

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

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

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

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

Signature of Licensee (Signature stamp will not be accepted) Date 8/25/06

29095 Eric M. Reuss, MD

ARIZONA MEDICAL BOARD
2004 BIENNIAL MD LICENSE RENEWAL APPLICATION

17080

AZ MD Lic#: 29095 Eric M. Reuss, MD **Renewal Fee: $500** **$850** (if postmarked after 11/21/2004)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 7331 E Osborn Dr Ste 305 Scottsdale AZ 85251-6422	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**
Phone #: (480) 945-4849 **Fax #:** **E-Mail:**	**Phone #:** **Fax #:** 480-945-0989 **E-Mail:**
MAILING ADDRESS 7331 E Osborn Dr Ste 305 Scottsdale AZ 85251-6422	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** **E-Mail:** [redacted]	**Phone #:** **Fax #:** **E-Mail:** **Cell Phone #:** (Optional)

RECEIVED
SEP - 7 2004
By

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**) [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 lawsuit resulted in a settlement or judgment against you? ☐ Yes ☒ No

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

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

[signature] MD
Signature of Licensee (Signature stamp will not be accepted)

8/17/04
Date

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

ARIZONA STATE BOARD OF MEDICAL EXAMINERS

2002 BIENNIAL MD LICENSE RENEWAL APPLICATION 16089

AZ MD Lic#: 29095 Eric M. Reuss, MD **Renewal Fee: $450** **$800** (if postmarked after **11/21/2002**)

CURRENT INFORMATION – Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS 7331 E Osborn Dr Ste 305 Scottsdale AZ 85251-6422 **Phone #:** (480) 945-4849 **Fax #:** **E-Mail:**	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** **Phone #:** **Fax #:** **E-Mail:** [redacted]
MAILING ADDRESS 7331 E Osborn Dr Ste 305 Scottsdale AZ 85251-6422	**MAILING A** [redacted]
HOME ADDRESS [redacted] **Phone #:** [redacted] **Fax #:** **E-Mail:**	**HOME ADDRESS** **Phone #:** **Fax #:** **E-Mail:** [redacted] **Cell Phone #:** (Optional)

RECEIVED SEP 09 2002 By

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

	Certified?	Practicing?
OBG	N	Y

Make corrections if necessary

	Certified?	Practicing?

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8. Have you consumed intoxicating beverages resulting in your present ability to exercise the judgment and skills of a medical professional, being impaired or limited?
9. Have you been denied a license in another state? If yes, ☐ Yes ☒ No
   State_____ Date of Denial_____ Reason for Denial_____
10. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? ☐ Yes ☒ No
    If yes, please attach an explanation and applicable court docket. See instructions on back.
11. Since your last renewal, has a malpractice 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. In addition, for all malpractice settlements and judgments, a copy of the National Practitioner Data Bank (NPDB) report should be submitted to the board. You may obtain this report by contacting the NPDB at (800) 767-6732 or online at www.npdb-hipdb.com.

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 of Licensee (Signature stamp will not be accepted)

8/27/02
Date

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