FEB 04 2008

ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

APPLICATION

Official Use Only: **Inquiry #** _____ **Date Application Received** _____

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

1. Present Name Beck (Last) Belinda (First) Kari (Middle) _____ (Maiden)

   (a) Other names used: None

2. Office/Training Address: 6620 (No.) Main Street (Street), Ste 1450 (Suite) Houston (City) TX (State) 77030 (Zip/Post Code)

3. All States or provinces in which you **have or had** a license or registration. If more than five, attach separate listing. If license is pending or was not issued, so state. If none, please indicate by stating "Not Applicable."

   (a) Texas (State Board) M4707 - Active (License No.)(Status of License, i.e., expired, active, etc.)

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

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

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

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

4. Medical School Name: University of Texas - Houston Medical School

   Medical School Location: Houston, Texas Date of Graduation: June 1 2003 (Month/Day/Year)

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

   ECFMG # _____ Certificate Date: _____ (Month/Day/Year)

5. List chronologically, all Internship, Residency and Fellowship training in U.S. or Canada **(COMPLETED OR NOT)**, or Assistant Professorship (or higher) at any programs attended, showing institution, address, type of program and dates. Attach separate listing if needed.

INSTITUTION NAME	CITY/STATE	TYPE OF PROGRAM/PGY YEAR	DATES OF ATTENDANCE
Thomas Jefferson University	Philadelphia, PA	Ob/Gyn/1	06/2003 - 01/2004
Baylor College of Medicine	Houston, TX	Ob/Gyn/1-4	02/2004 - 06/2007
Baylor College of Medicine	Houston, TX	Gyn/5 (Slope Specialization)	07/2007 - Present

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

a. United States Medical Licensing Exam (USMLE)

6/28/01	9/27/02	8/11/05	TX
Step I (Date)	Step II (Date)	Step III (Date)	State

b. State Written Examination Date _____ State _____
(The Commonwealth of Puerto Rico written examination is not accepted)

c. National Board of Medical Examiners Examination (NBME) Certification Date _____

d. Federation of State Medical Boards Licensing Examination (FLEX) Date(s) _____ _____
Comp I (Date) Comp II (Date)

e. Licentiate of the Medical Council of Canada (LMCC) Date _____

f. Special Purpose Examination (SPEX) Date _____ State _____

7. Indicate your area of practice: Obstetrics and Gynecology - Specialization in Minimally Invasive Gyn. Surgery

8. List all certifications and re-certifications by a board or sub-board recognized by the **American Board of Medical Specialties only.**

Specialty Board	Certification #	Dates of Certification/Recertification	Expiration Date
ABOG - Written Only		Board Eligible 06/2007	→ oral boards eligible

9. Account for, in **chronological order,** all activities since graduation from medical school to present. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. Attach a separate sheet if necessary. DO NOT ATTACH A CURRICULUM VITA (CV).**

ACTIVITIES	LOCATION	FROM/TO (MONTH/YEAR)
(e.g.) Prepare for USMLE/Vacation	City/State	06/99 to 01/00
Internship - Thomas Jefferson	Philadelphia, PA	06/03 to 01/04
Residency - Baylor College	Houston, TX	02/04 to 06/07
Clinical Instructor/Fellowship (BCM)	Houston, TX	06/07 to present

10. Have you ever had any application for any professional license refused or denied by any licensing authority?	YES ☐	NO ☒
11. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐	NO ☒
12. Have you ever been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled?	YES ☐	NO ☒
13. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently?	YES ☒	NO ☐
14. Have you ever voluntarily surrendered any healthcare license?	YES ☐	NO ☒
15. Have you ever had any healthcare license revoked?	YES ☐	NO ☒
16. Have you ever been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☒
17. Have your privileges ever been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☒
18. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.	YES ☐	NO ☒
19. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?.	YES ☐	NO ☒
20. Have you ever had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	YES ☐	NO ☒
21. Have you ever been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) **A "yes" answer is required even if you entered a diversion program.**	YES ☐	NO ☒
22. Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES ☐	NO ☒
23. In the last ten (10) years has a judgment or settlement been entered against you as a defendant in a medical malpractice suit? ***Please do not report pending malpractice suits or settlements paid not related to a civil action.**	YES ☐	NO ☒
24. Have you ever been court martialed or discharged other than honorably from the armed service?	YES ☐	NO ☒
25. Have you ever been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐	NO ☒
26. Have you ever been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	YES ☐	NO ☒

Note: ***In the event the response to any of the questions numbered 10 through 26 is "YES"*****, the applicant must file with the application a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such charge(s). IN ADDITION, the applicant must submit photocopies of any complaints, hearings, settlements or judgments together with copies of patient's hospital and/or office records to the AMB.**

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

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

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

[redacted]

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

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

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

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

FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION, INCLUDING REVOCATION OR DENIAL OF A LICENSE.

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.

Applicant Name Belinda Beck, M.D. (4)

The applicant Belinda K. Beck

(PRINT OR TYPE YOUR NAME)

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

Under penalty of perjury I certify I am a U.S. Citizen or a qualified/registered alien.

Signature of Applicant _____, **M.D.** **Date** 1/24/08

If you would like to designate/authorize ONE other individual beside yourself to check the status of your application with the AMB, please complete the following information:

Entity name:_____ Individual Name_____ Phone #_____

*** ARIZONA LAW REQUIRES AN APPLICANT WHO HAS BEEN CHARGED WITH A FELONY OR A MISDEMEANOR INVOLVING CONDUCT THAT MAY AFFECT PATIENT SAFETY AFTER SUBMITTING THE APPLICATION TO NOTIFY THE AMB WITHIN 10 DAYS AFTER THE CHARGE IS FILED. ARIZONA REVISED STATUTE (A.R.S.) §32-3208 (SEE WEBSITE UNDER *Physician Center – Reportable Misdemeanors* FOR LIST OF REPORTABLE MISDEMEANORS – ALL FELONIES ARE REPORTABLE.)**

FOR OFFICIAL USE ONLY

Application Processed by bdiaz 2/29/08

Application Approved 3/4 20 08 by Marie Slaughter

License Issued 3/12/08 JY License Number 38131

Pd ce

Arizona Medical Board
9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514
Telephone: 480-551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov • Email: questions@azmd.gov

RECEIVED
MAR 11 2008
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

March 4, 2008

Belinda K. Beck, M.D.
[redacted]

Dear Dr. Beck:

The Arizona Medical Board is pleased to inform you that your application for licensure in the State of Arizona is administratively complete and 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 on** [redacted]

As of January 2001 Arizona converted to biennial licensure based on birth month and odd or even birth year. **Your required license registration fee is $437.50.** This fee is your licensing fee and is in addition to the $500.00 application processing fee that you have already paid.

Please complete the bottom portion of this letter and return the completed form with the initial license registration fee payable to the Arizona Medical Board, 9545 E. Doubletree Ranch Rd., Scottsdale, AZ 85258. If paying by credit card, the completed form along with the payment card authorization must be returned. 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. **Allow up to 5 business days for the processing of your payment and issuance of your license. Please do not call and request status, as this will slow down the process.**

Registration forms and initial license fees not returned **postmarked within thirty-five days** of this notice will result in the application being withdrawn and applicant will be required to reapply.

If you have any questions, please contact me by e-mail at bdiaz@azmd.gor or by telephone at (480) 551-2752.

Sincerely,

Brenda J. Diaz
Administrative Support Supervisor

(DO NOT DETACH)

Name: Belinda Beck

Current Office Address: One Baylor Plaza Houston, TX 77030

Current Home Address: [redacted]

Current Mailing Address: [redacted]

Current Office Telephone (713)509-2319 Current Home Telephone [redacted]

Current Office E-Mail [redacted] Current Home E-Mail [redacted]

Field of Practice: Ob/Gyn Practicing (Yes) No

NOTE: Statutes require you to provide the Board with written notification within thirty days (30) of any changes in addresses or phone numbers.

#38131 3/12/08

ENTERED

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700Fax: 480-551-2704
www.azmd.gov

RECEIVED
JAN 28 2008
ARIZONA MEDICAL BOARD
BOARD SERVICES

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 **Dean or the Registrar** of all medical schools attended. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax. Your prompt response will be appreciated.

Applicant Name: Belinda Beck, M.D.

Signature

1-23-08
Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by an official of the Medical school.

This certifies that Belinda Kari Beck
(Name of applicant)

was enrolled in University of Texas Health Science Center at Houston
(Name of Medical School) (Location – City/State)

The undersigned further certifies that the records of this institution show that the applicant attended this institution

from August 17, 1998 (month/year) to May 31, 2003 (month/year)

Please check one: X The applicant was granted a medical degree by

_____ The applicant withdrew from

the above named Medical School on June 7, 2003
(month /day /year)

JAN 23 2008
Robert L. Jenkins
REGISTRAR

Advanced credits – Credits granted upon admission

(name of medical school)	(total credits)	(dates attended)

(SEAL OF COLLEGE)

(If no seal, please indicate)

Signed: Robert L Jenkins

Name Typed or Printed: Robert L. Jenkins

Title: Registrar Date January 23, 2008

Address: 7000 Fannin Houston Texas 77030

Telephone number: 713-500-3361 Fax number: 713-500-3356

VERIFIED
Licensing

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700Fax: 480-551-2704
www.azmd.gov

FEB 19 2008
BOARD

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 the **Program Director** of each postgraduate training program in the United States, its territories, and/or Canada that I participated in. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECTLY to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax. Your prompt response will be appreciated.

Applicant Name: Belinda Beck, M.D.

Signature 1-24-08 Date (Month/Day/Year)

(DO NOT DETACH)

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

PG/Year: 1 **DEPARTMENT/SPECIALTY:** OB/GYN
✓ **Internship**
Residency **From:** 6/20/2003 **To:** 2/1/2004
Fellowship
Research **Successfully completed?** **Yes** ✓ **No** **In Progress**

PG/Year: **DEPARTMENT/SPECIALTY:**
Internship
Residency **From:** / / **To:** / /
Fellowship
Research **Successfully completed?** **Yes** **No** **In Progress**

PG/Year: **DEPARTMENT/SPECIALTY:**
Internship
Residency **From:** / / **To:** / /
Fellowship
Research **Successfully completed?** **Yes** **No** **In Progress**

Circle the correct response to the question below:
This program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education (ACGME), or the Royal College of Physicians and Surgeons of Canada. **(Yes)** **No**

Circle the correct response to the questions below: ("Yes" responses require written explanation.)
Did this individual ever take a leave of absence or break from their training? **Yes** **(No)**

Was this individual disciplined and/or placed under investigation or on probation? **Yes** **(No)**

Please explain below any "Yes" responses(s) to the above two questions. If necessary, you may continue your explanation on a separate sheet of paper.

Signed: Carmen T Sultan (SEAL OF TRAINING PROGRAM)
(If no seal, please indicate)
Name Typed or Printed: CARMEN T SULTAN
Title: RESIDENCY PROGRAM DIRECTOR Date 2/11/08
Full name of Hospital or Program THOMAS JEFFERSON UNIVERSITY HOSPITAL
Address: 834 CHESTNUT ST. STE. 400 PHILADELPHIA PA 19107
Telephone number: 215-955-1085 Fax number: 215-955-5041

VERIFIED
Licensing 2/4

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.azmd.gov

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 the **Program Director** of each postgraduate training program in the United States, its territories, and/or Canada that I participated in. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax. Your prompt response will be appreciated.

Applicant Name: Belinda Beck, M.D.

Signature 1-23-08 Date (Month/Day/Year)

(DO NOT DETACH)

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

PG/Year: 2-4 DEPARTMENT/SPECIALTY: Obstetrics & Gynecology
_____ Internship
✓ Residency From: 6 / 30 / 2004 To: 06 / 24 / 2007
_____ Fellowship
_____ Research Successfully completed? _____ Yes _____ No _____ In Progress

PG/Year: 1 DEPARTMENT/SPECIALTY: Department of Obstetrics & Gynecology
✓ Internship
_____ Residency From: 2 / 1 / 2004 To: 6 / 30 / 2004
_____ Fellowship
_____ Research Successfully completed? ✓ Yes _____ No _____ In Progress

PG/Year: _____ DEPARTMENT/SPECIALTY: _____
_____ Internship
_____ Residency From: ___/___/___ To: ___/___/___
_____ Fellowship
_____ Research Successfully completed? _____ Yes _____ No _____ In Progress

Circle the correct response to the question below:
This program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education (ACGME), or the Royal College of Physicians and Surgeons of Canada. (Yes) No

Circle the correct response to the questions below: ("Yes" responses require written explanation.)
Did this individual ever take a leave of absence or break from their training? Yes (No)

Was this individual disciplined and/or placed under investigation or on probation? Yes (No)

Please explain below any "Yes" responses(s) to the above two questions. If necessary, you may continue your explanation on a separate sheet of paper.

Signed: Amy Young MD
Name Typed or Printed: Amy Young, MD
Title: Program Director
Date 1/31/08
(SEAL OF TRAINING PROGRAM)
(If no seal, please indicate)
Full name of Hospital or Program Baylor College of Medicine
Address: 1709 Dryden Ste. 1100, Houston, TX 77030
Telephone number: 713 798-7355 Fax number: 713 798-8410

2/4

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date : 01/25/2008

Recipient:

Arizona Medical Board
ATTN: Lisa Wynn
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258

Examinee: Beck, Belinda
Alt Name(s): Beck, Belinda Kari

Examinee ID#: 5-070-083-0
Date of Birth: [redacted]

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

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/28/2001	Pass	205	182	83	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	09/27/2002	Pass	212	174	85	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
TEXAS	08/11/2005	Pass	216	184	89	75	

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

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Please mail or fax this form to:

Arizona Medical Board
Arizona Regulatory Board of Physician Assistants
Attention: Licensing Office
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258
Fax: 480-551-2704

ADDRESS CHANGE FORM

- You must notify the board in writing within 30 days of any change of office or home address and phone number
- Failure to do so may result in a monetary fine of $100 plus the costs incurred by the Board to locate you
- Please print this from and provide all information on your address change as requested below. Please type or print legibly. Fax or mail the completed form to the Board
- In accordance with A.R.S. §32-3801, notwithstanding any law to the contrary, a professional's residential address and residential telephone number or numbers maintained by the professional board established pursuant to this title are not available to the public unless they are the only address and numbers of record.

Please record the following address changes: **EFFECTIVE DATE:** 6/20/08

PRACTICE: Phoenix Gynecology Consultants (Company Name) (If you do not have a practice address or name, write the word "NONE")

Street Address Only: 3410 N. 4th Ave
(list P.O. Box as Mailing Address below)*

City: Phoenix **State:** AZ **Zip:** 85013

Office Telephone: (602) 241-1944 **Office Fax:** (602) 241-1917

Office E-Mail: [redacted]

RESIDENCE ADDRESS: [redacted]

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

Telephone: [redacted] **Cell Phone:** [redacted]

Residence E-Mail: [redacted]

MAIL SHOULD BE SENT TO MY: Practice ☒ Residence ☐ The Address Below ☐

MAILING ADDRESS: _____
(If different from either above)

Street or P.O. Box: _____

City: _____ **State:** _____ **Zip:** _____

****If no practice address, do you want your home address listed on the website?** Yes ☐ No ☐

Belinda Bach
Name (Please print)

38131
AZ License #

Signature

6/16/08
Today's Date

CR1700410

RECEIVED
APR 04 2016
ARIZONA MEDICAL BOARD

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2707
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Belinda K. Beck

LICENSE #: 38131 SPECIALTY: Obstetrics & Gynecology

CHECK ONE: **Initial Registration ($200)** **Renewal Registration ($150)**

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE

A ***separate*** DEA license must be submitted for ***EACH*** location where controlled substances will be dispensed and must be kept current during the registration period

PRIMARY PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** [redacted]

Street Address				City/State/Zip Code			
5771 W. EUGIE AVE				GLENDALE, ARIZONA 85304			
Phone Number				**Fax Number**			
623-934-7006				623-937-3014			
Schedule II Drugs	X	Schedule III Drugs	X	Prescription-Only Drugs		Nubain	
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** [redacted]

Street Address				City/State/Zip Code			
1250 E. APACHE #108				TEMPE, ARIZONA 85281			
Phone Number				**Fax Number**			
480-966-4728				480-921-8712			
Schedule II Drugs	X	Schedule III Drugs	X	Prescription-Only Drugs		Nubain	
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices			

***** List any additional locations on the 2nd page of this form and place a check mark here: X

Physician's Signature: _____ Date: 3/29/16

Initial registration fee: $200.00 *per physician* Renewal registration fee: $150.00 *per physician*

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa, MasterCard or American Express

If you wish to pay by payment card, please complete the attached PAYMENT CARD AUTHORIZATION FORM

ENTERED

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION** [redacted]

Street Address				City/State/Zip Code			
5240 E. KNIGHT DR, #112				TUCSON, ARIZONA 85712			
Phone Number				**Fax Number**		[redacted]	
520-323-9210				520-323-9689			
Schedule II Drugs	X	**Schedule III Drugs**	X	**Prescription-Only Drugs**		**Nubain**	
Schedule IV Drugs	X	**Schedule V Drugs**	X	**Prescription Devices**			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** n/a

Street Address				City/State/Zip Code			
4751 N. 15TH ST				PHOENIX, ARIZONA 85014			
Phone Number				**Fax Number**		[redacted]	
602-263-2220				602-916-0600			
Schedule II Drugs		**Schedule III Drugs**		**Prescription-Only Drugs**		**Nubain**	
Schedule IV Drugs		**Schedule V Drugs**		**Prescription Devices**			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** n/a

Street Address				City/State/Zip Code			
610 N. ALMA SCHOOL RD, #48				CHANDLER, ARIZONA 85224			
Phone Number				**Fax Number**		[redacted]	
480-814-1479				480-814-1095			
Schedule II Drugs		**Schedule III Drugs**		**Prescription-Only Drugs**		**Nubain**	
Schedule IV Drugs		**Schedule V Drugs**		**Prescription Devices**			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** n/a

Street Address				City/State/Zip Code			
4616 N. 51ST AVE, #210				PHOENIX, ARIZONA 85031			
Phone Number				**Fax Number**		[redacted]	
623-209-9838				623-209-9843			
Schedule II Drugs		**Schedule III Drugs**		**Prescription-Only Drugs**		**Nubain**	
Schedule IV Drugs		**Schedule V Drugs**		**Prescription Devices**			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** n/a

Street Address				City/State/Zip Code			
1235 S. GILBERT RD.				MESA, ARIZONA 85204			
Phone Number				**Fax Number**		[redacted]	
480-926-2741				480-892-0403			
Schedule II Drugs		**Schedule III Drugs**		**Prescription-Only Drugs**		**Nubain**	
Schedule IV Drugs		**Schedule V Drugs**		**Prescription Devices**			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** n/a

Street Address				City/State/Zip Code			
3131 E. THUNDERBIRD RD, #48				PHOENIX, ARIZONA 85032			
Phone Number				**Fax Number**		[redacted]	
602-996-1897				602-953-8062			
Schedule II Drugs		**Schedule III Drugs**		**Prescription-Only Drugs**		**Nubain**	
Schedule IV Drugs		**Schedule V Drugs**		**Prescription Devices**			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** n/a

Street Address	City/State/Zip Code	
2255 N. WYATT DR.	TUCSON, ARIZONA 85712	
Phone Number	**Fax Number**	[redacted]
520-624-1766	520-628-3069	

Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** n/a

Street Address	City/State/Zip Code	
7901 E. THOMAS RD, #106	SCOTTSDALE, ARIZONA 85251	
Phone Number	**Fax Number**	[redacted]
480-949-0049	480-429-2326	

Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address	City/State/Zip Code	
Phone Number	**Fax Number**	**E Mail**

Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address	City/State/Zip Code	
Phone Number	**Fax Number**	**E Mail**

Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address	City/State/Zip Code	
Phone Number	**Fax Number**	**E Mail**

Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address	City/State/Zip Code	
Phone Number	**Fax Number**	**E Mail**

Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

BECK, BELINDA K MD
PLANNED PARENTHOOD
4751 N. 15TH STREET
PHOENIX, AZ 85014-0000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	07-31-2016	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	06-04-2013

BECK, BELINDA K MD
PLANNED PARENTHOOD
5771 W EUGIE AVE
GLENDALE, AZ 85304-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	07-31-2016	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	06-04-2013

BECK, BELINDA K MD
PLANNED PARENTHOOD
5771 W EUGIE AVE
GLENDALE, AZ 85304-0000

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Form DEA-223 (4/07)

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	07-31-2016	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	06-04-2013

BECK, BELINDA K MD
PLANNED PARENTHOOD
5771 W EUGIE AVE
GLENDALE, AZ 85304-0000

CONTROLLED SUBSTANCE/REGULATED CHEMICAL REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

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Form DEA-223/511 (4/07)

REPORT CHANGES PROMPTLY

REQUESTING MODIFICATIONS TO YOUR REGISTRATION CERTIFICATE

To request a change to your registered name, address, the drug schedule or the drug codes you handle, please

1. visit our web site at **deadiversion.usdoj.gov** - or
2. call our customer Service Center at **1-(800) 882-9539** - or
3. submit your change(s) in writing to:

Drug Enforcement Administration
P.O. Box 28083
Washington, DC 20083

See Title 21 Code of Federal Regulations, Section 1301.51 for complete instructions.

You have been registered to handle the following chemical/drug codes:

BECK, BELINDA K MD
PLANNED PARENTHOOD OF ARIZONA INC
4751 N. 15TH STREET
PHOENIX, AZ 85014-0000

10015861/000064

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	07-31-2018	$731
SCHEDULES	**BUSINESS ACTIVITY**	**ISSUE DATE**
2,2N, 3,3N,4,5,	PRACTITIONER	03-24-2016

BECK, BELINDA K MD
1250 E APACHE #108
TEMPE, AZ 85281-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

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UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	07-31-2018	$731
SCHEDULES	**BUSINESS ACTIVITY**	**ISSUE DATE**
2,2N, 3,3N,4,5,	PRACTITIONER	03-24-2016

BECK, BELINDA K MD
1250 E APACHE #108
TEMPE, AZ 85281-0000

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DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	07-31-2018	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	03-24-2016

BECK, BELINDA K MD
1250 E APACHE #108
TEMPE, AZ 85281-0000

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   Washington, DC 20083

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BECK, BELINDA K MD
PLANNED PARENTHOOD OF ARIZONA, INC
4751 N. 15TH STREET
PHOENIX, AZ 85014-0000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	07-31-2018	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	03-24-2016

BECK, BELINDA K MD
5240 E KNIGHT DR #112
TUCSON, AZ 85712-0000

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UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

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WASHINGTON D.C. 20537

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[redacted]	07-31-2018	$731

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TUCSON, AZ 85712-0000

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[redacted]	07-31-2018	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
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BECK, BELINDA K MD
5240 E KNIGHT DR #112
TUCSON, AZ 85712-0000

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DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

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2. call our customer Service Center at **1-(800) 882-9539** - or
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   Drug Enforcement Administration
   P.O. Box 28083
   Washington, DC 20083

See Title 21 Code of Federal Regulations, Section 1301.51 for complete instructions.

You have been registered to handle the following chemical/drug codes:

ARIZONA MEDICAL BOARD
MD RENEWAL
CONFIDENTIAL QUESTION ADDENDUM

Revised10/20/2015

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

RECEIVED
DEC 11 2015
ARIZONA
MEDICAL BOARD

Questionnaire

1. Since 2009, 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]

2. Have you received treatment within the last five years 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 judgement 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]

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

Full Name (print): Belinda Beck, MD

Signature: [signature]

Date: 12/7/15

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 s, 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.

Belinda Beck, MD

[redacted]

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

852BEE1445

Arizona Medical Board

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

Governor

Douglas A. Ducey

Members

Richard Perry, M.D.
Chair
Physician Member

James Gillard, M.D.
Vice-Chair
Physician Member

Jodi Bain, Esq.
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Public Member

Marc Berg, M.D.
Physician Member

Donna Brister
Public Member

Teresa Connolly, D.N.P.
Public Member

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Physician Member

Gary R. Figge, M.D.
Physician Member

Robert E. Fromm, M.D.
Physician Member

Lois E. Krahn, M.D.
Physician Member

Edward G. Paul, M.D.
Physician Member

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

Executive Director

Patricia E. McSorley

December 4, 2015

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

Dr. Belinda Beck
[redacted]

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

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

1.) **Please complete attached application addendum.** (this is an updated questionnaire, please complete and return)
2.) **Please provide government issued document that contains a photograph**. (ie: passport, driver's license)

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

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

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

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

C. The licensee shall submit proof with the renewal form of having completed a training unit as prescribed by the board relating to the requirements of this chapter and board rules.
D. A person whose license has expired may reapply for a license to practice medicine as provided in this chapter.

R4-16-207. Time-frames for License Renewal; Expiration
B. For license renewal, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is 45 days and begins on the date the Board receives the renewal application.
1. If the required application is not administratively complete, the Board shall send a written deficiency notice to the applicant.
a. In a deficiency notice, the Board shall state each deficiency and the information required to complete the application or supporting documentation.
b. Within 60 days after the Board sends a deficiency notice, the applicant shall submit to the Board the requested documentation or information specified in the notice. The time-frame for the Board to finish the administrative completeness review is suspended from the date of the notice until the date the Board receives the requested documentation or information from the applicant.
D. If a person holding an active license does not apply for license renewal according to the biennial renewal requirement or fails to meet time-frame requirements under this Section, the person's license expires according to provisions prescribed under A.R.S § 32-1430(A) unless the person is under investigation according to provisions prescribed under A.R.S. § 32-3202.

Sara Bachmann
Arizona Medical Board
Licensing Renewal Coordinator
Sara.Bachmann@azmd.gov

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

11/9/2015

Belinda Kari Beck

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	01/15/2010	12/31/2015
Specialty 2					
Specialty 3					
Specialty 4					

Practice Address

Phoenix Gynecology Consultants 1008 E. McDowell Rd
Phoenix AZ, 85006
Phone: (602) 358-8588
Fax: (602) 241-1917

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

Home Address

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

Mailing Address

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

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

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

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

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

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

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

MD Training Unit

Complete

You may wish to print this Page for your records.

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

Arizona Medical Board: License Renewal Questions

Belinda Beck 2013 License # 38131 Professional Conduct

1. Since your last renewal have you had an application for medical licensure denied or rejected by another state or province licensing board?	**No**	
2. Since your last renewal has disciplinary or rehabilitative action been taken against you by another licensing board, including other health professions?	**No**	
3. Since your last renewal have any disciplinary actions, restrictions or limitations taken against you while participating in any type of training program or by any health care provider?	**No**	
4. Since your last renewal have you been found in violation of a statute, rule, or regulation of any domestic or foreign governmental agency?	**No**	
5. Since your last renewal have you been under investigation by any medical board or peer review body?	**No**	
6. Since your last renewal, have you had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation during an investigation or entered into a consent agreement or stipulation?	**No**	
7. Since your last renewal, have you had hospital privileges revoked, denied, suspended, or restricted?	**No**	
8. Since your last renewal, have you been named as a defendant in a malpractice matter currently pending or that resulted in a settlement or judgment against you?	**No**	
9. 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?	**No**	
10. Since your last renewal, have you had your authority to prescribe, dispense, or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency?	**No**	
11. Since your last renewal, have you engaged or do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication?	[redacted]	
12. 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?	**No**	

Arizona Medical Board: License Renewal Questions

Belinda	Beck	2013	License # 38131	Mental Health

1. Since your last renewal have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine including a diagnosis or treatment for any psychotic disorder or substance abuse disorder?

2. Since your last renewal, have you consumed intoxicating beverages resulting in your ability being impaired or limited to exercise the judgment and skills of a medical professional?

[redacted]

Arizona Medical Board: License Renewal Questions

Belinda Beck 2011 License # 38131 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

Belinda	Beck	2011	License # 38131	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?	[redacted]
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.	

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

Ck 1200 CME VDIC

AZ MD Lic#: 38131 **Renewal Fee:** **$500** / **$850** (if postmarked 30 days after due date)

Name: Belinda K. Beck , **MD**

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

3410 N. 4th Ave
Phoenix AZ 85013

Phone #: 602-889-2030 **Fax #:** 602-241-1917

E-Mail: [redacted]

MAILING ADDRESS (REQUIRED)

3410 N. 4th Ave
Phoenix AZ 85013

AZ MEDICAL BOARD
RECEIVED
OCT 21 2009

HOME ADDRESS (REQUIRED)

[redacted]

Phone #: [redacted]

Mobile #:

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

Field of Practice Code (see attached form for code)	**ABMS Certified? (Y/N)**	**Practicing? (Y/N)**	**Expiration Date** (or indicate lifetime certificated)
GYN	Eligible	Y	N/A

REQUEST FOR CHANGE IN LICENSE STATUS:

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

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

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

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

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

Signature of Licensee (Signature stamp will not be accepted) 10/22/09 Date

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: Belinda K. Beck, MD License Number: 38131

Signature: _____

CONFIDENTIAL

Physician Health Program

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.

[redacted]

In the event you answer YES to any of the above questions, **you must file with the application a detailed written narrative statement concerning the above matter(s), including the name 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 a compliance reports from the state monitoring programs**

FAILURE TO PROPERLY ANSWER THESE QUESTIONS CAN RESULT IN BOARD DISCIPLINARY ACTION, INCLUDING REVOCATION OR DENIAL OF A LICENSE.

(THIS SECTION INTENTIONALLY LEFT BLANK)

Name: Belinda K. Beck, MD License Number: 38131

Signature: _____