DEC 0 1 1994

ARIZONA BOARD OF MEDICAL EXAMINERS

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

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE THROUGH ENDORSEMENT

FOR BOARD USE
DO NOT USE THIS SPACE

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

INFORMATION

All candidates shall provide satisfactory evidence that:

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

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 Applications not fully complete within one year from date of receipt are considered withdrawn.

APPLICATION INSTRUCTIONS
(Read Carefully)

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

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

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

UNITED STATES OR CANADIAN MEDICAL SCHOOL GRADUATES

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

ALL OTHER MEDICAL SCHOOL GRADUATES

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

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

APPLICATION

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

1. Present Legal Name: PRINT OR TYPE Yunis (Last) Ronald (First) Alexander (Middle)
   (a) Other names used: [redacted] Social Security No. [redacted]
2. Address: Residence [redacted]
   Office _____ (No.) (Street) (City) (State) (Zip Code) (Phone)
3. City and State of Birth [redacted] Month, Day and Year of Birth [redacted]
4. In what states or provinces have you applied for or been granted license or registration? If more than two, attach separate listing. If license not issued, so state.
   (a) _____ (Specify State Board) (Date of Application) (Result) (Certificate No.)
   _____ (Date Issued) (Specify if by Written Examination or on Credentials)
   (b) _____ (Specify State Board) (Date of Application) (Result) (Certificate No.)
   _____ (Date Issued) (Specify if by Written Examination or on Credentials)
5. Have you ever had an application for a license to practice medicine denied or rejected by another state/province licensing Board? No (Answer)
6. Have any actions, restrictions, limitations, or probations ever been imposed on you while participating in any type of training program? No (Answer)
7. Have you ever been charged with a violation of any statute, rule or regulation of any domestic or foreign governmental agency? No [redacted] (Answer)
8. Has there been any action initiated against you by or through any medical board or association? No (Answer)
9. Have you ever had a medical license revoked; suspended; limited; restricted; placed on probation; voluntarily surrendered or cancelled during an investigation or in lieu of disciplinary action; or entered into a consent agreement or stipulation? No (Answer)

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

11. Have you ever been involved in any malpractice matter which resulted in a settlement or judgement against you in excess of $20,000? No (Answer)

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

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

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

14. Have you ever been treated for the use of or misuse of any chemical substance or substances?

15. Have you ever been hospitalized or a patient in a mental or other institution of confinement, or have you ever been treated or received medication for a mental or behavioral condition?

16. Are you suffering from any ailment communicable to others?

[redacted]

Note: In the event the response to the questions 14 through 16 is YES, the applicant will file with the application a separate detailed statement concerning the above matter(s); including the name and address of the hospital/rehabilitation center where treatment was obtained. The applicant shall also obtain and furnish a certified copy of his/her History and Physical Examination, Consultation Report(s), and Discharge Summary from the hospital/rehabilitation center. The applicant shall also have submitted a statement from his/her attending physician or treating therapist setting forth the applicant's diagnosis, prognosis and recommendations for continuing care, treatment and supervision.

17. Are you presently in good physical and mental health?

(If NO, applicant shall file with this application, a detailed statement of his health, diagnosis and prognosis, supported by report of his attending physician.)

18. Enter your height here 5'10" weight 180 color of eyes GREEN color of hair BROWN

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

INTERNSHIP: Phoenix Residency in Obstetrics + Gynecology (PIROG), Maricopa medical Center, Phoenix, AZ

Current: PGY-2, Texas Tech/University Health Sciences Ctr. Lubbock, Texas OB/GYN

20. Are you certified by an American Board of medical specialties? No Specialty: _____

21. Have you completed the educational requirements for any of the American Board of medical specialties? No If so, which? _____

22. 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 Phoenix (City) AZ (State) from 8/93 to 8/94

At Lubbock (City) TX (State) from 8/94 to Present

At _____ (City) _____ (State) from _____ to _____

At _____ (City) _____ (State) from _____ to _____

At _____ (City) _____ (State) from _____ to _____

At _____ (City) _____ (State) from _____ to _____

23. In the event you are successful in obtaining a license to practice medicine by this application, have you selected a location?
No Where? _____
Solo or in Association with? UNSURE

24. What is your intended specialty practice? Ob/Gyn

25. What branch of the United States Armed Forces have you served with, if any, including USPHS? None
Active duty? From _____ to _____
Month and Year Month and Year

The applicant RONALD ALEXANDER YUNIS
(PRINT OR TYPE) (Name in Full)

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

Signature of Applicant _____, M.D.

STATE OF TEXAS
County of LUBBOCK } ss

(NOTARIAL SEAL)

Subscribed and sworn to before me this 13th day of December 19 94

Notary Signature Cheryl J. Roper My Commission expires 12-15-94
(Notary Public)

FOR OFFICE USE ONLY

Application Rec'd	19	Application Processed by	
Application Completed	19	Application Checked by	ms
Form No. I Rec'd 4-10	19 95	Application Approved	19
Form No. II Rec'd 1-20	19 95	By	Marci Naughton
Form No. III Rec'd 2-24	19 95	License Issued 5-2	19 97
Form No. III Rec'd 5 22	19 95	License No.	25201
Form No. III-A Rec'd 2-25	19 97		
Form No. IV Rec'd	19		
Investigation Completed	19		

Application withdrawn _____
(Date)

PLEASE RETURN THIS FORM WITH YOUR APPLICATION
MAY BE XEROXED IF ADDITIONAL COPIES ARE NEEDED

ARIZONA BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

APPLICANTS: List all hospital affiliations for the past five (5) years, including moonlighting and courtesy staff affiliations.

List all employment with medical agencies of employment, e.g., physician placement group; emergency medical group radiology group; etc.

Training
1) HOSPITAL: Maricopa Medical Center, John V. Kelley, M.D.

ADDRESS: Phoenix Az. 85
City State Zip Code

DATE OF STAFF MEMBERSHIP: 8/93 - 8/94

TYPE OF STAFF MEMBERSHIP: Intern Ob/Gyn

Training
2) HOSPITAL: St. Joseph's Hospital, James Mouer, M.D.

ADDRESS: Phoenix Az 85
City State Zip Code

DATE OF STAFF MEMBERSHIP: 8/93 - 8/94.

TYPE OF STAFF MEMBERSHIP: Intern Ob/Gyn. Daniel E. McGuegle, M.D.

Training
3) HOSPITAL: Texas Tech University Health Sciences CTR.
2-27-97

ADDRESS: 4th St. Lubbock Tx. 79430
City State Zip Code

DATE OF STAFF MEMBERSHIP: 8/94 - present

TYPE OF STAFF MEMBERSHIP: PGY-2 Ob/Gyn.

4) HOSPITAL:

ADDRESS:
City State Zip Code

DATE OF STAFF MEMBERSHIP:

TYPE OF STAFF MEMBERSHIP:

5) MEDICAL AGENCY OF EMPLOYMENT:

ADDRESS:
City State Zip Code

DATE OF EMPLOYMENT:

6) MEDICAL AGENCY OF EMPLOYMENT:

ADDRESS:
City State Zip Code

DATE OF EMPLOYMENT:

PHOTO ON BACK

FORM I

MEDICAL COLLEGE CERTIFICATION

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

Name: RONALD ALEXANDER YUNIS , M.D. R. Y. , M.D.
(Please Print or Type) (Signature)

Address: [redacted]
(Street) (City and State)

Date: 12/6/94

(DO NOT DETACH)

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

This is to certify that RONALD ALEXANDER YUNIS
(Full Name of Student)

whose photograph is attached hereto, was granted the degree of Doctor of Medicine by Mount Sinai School of Medicine on May 18 19 93,
(Full Name of School or College of Medicine as it appears on the Applicant's Medical degree diploma)

that the date of his/~~her~~ matriculation in medical school was August 14, 19 89; and that he/she attended Necessary (Number) full courses of medical lectures comprising Required (Number) [redacted] months each as verified by the attached certified copy of his/her transcripts.

1. Was applicant ever required to repeat any segment of training? NO If YES, which part(s)? N/A

2. Was applicant ever placed on probation, restricted or limited? NO If YES, please attach written explanation.

3. Was there any reason not to continue applicant in the training program? NO If YES, please attach written explanation.

4. Was applicant ever known to use or misuse any chemical substance or substances which required treatment or counseling [redacted] If YES, please attach written explanation.

5. Was applicant ever known to suffer from any mental health disorders which required treatment, counseling or medications? [redacted] If YES, please attach written explanation.

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

Signed Marie J. Allen , M.D.

Dean / President / Secretary / Registrar of Mount Sinai School of Medicine (SEAL OF COLLEGE)

Date Mar. 13, , 19 95

Address: One Gustave L. Levy Pl. NY NY 10029

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

Revised 4/91

RECEIVED B.O.M.E.X.
JUN -9 95

[redacted]

must assume the responsibility for completion of this form and is
at it must be fully completed and forwarded to the Arizona Board
aminers before any application may be considered.

Is your RETURN ADDRESS completed on the reverse side?

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

LL

I also wish to receive the following services (for an extra fee):
1. ☐ Addressee's Address
2. ☐ Restricted Delivery

Consult postmaster for fee.

3. Article Addressed to:
Ronald A. Yunis and
[redacted]

4a. Article Number
P 578 819 095

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

7. Date of Delivery

5. Received By: *(Print Name)*
RONALD YUNIS.

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

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

PS Form **3811,** December 1994 Domestic Return Receipt

Thank you for using Return Receipt Service.

The Board of Trustees
on recommendation of the Faculty of

Mount Sinai School of Medicine

of the
City University of New York
confers upon

Ronald Alexander Yunis

the degree of

Doctor of Medicine

In recognition of fulfillment of the requirements for this degree, with all the rights, privileges and honors appertaining thereto.
In testimony thereof, this diploma is duly sealed with the seal of the school and signed by the Chairman of the Board of Trustees and the President and Dean of Mount Sinai School of Medicine and the Chancellor of the City University of New York.
Dated at the City of New York, this eighteenth day of May, nineteen hundred and ninety-three.

W. Ann Reynolds
Chancellor of the University

John W Rowe
President

MOUNT SINAI MSM 1963 SCHOOL OF MEDICINE

Chairman, Board of Trustees

Nathan Kase
Dean

FORM III

POSTGRADUATE TRAINING CERTIFICATION

TO WHOM IT MAY CONCERN:

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

Name: RONALD ALEXANDER YUNIS, M.D. R. Y., M.D.
(Please Print or Type) (Signature)

Address: [redacted]
(Street) (City and State)

Date: 12/6/94

(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 of approved post-graduate training in the United States or Canada.)

This is to certify that RONALD ALEXANDER YUNIS, M.D. undertook and
(Name of Applicant in Full)

satisfactorily completed a full term approved program of 12 months in the: Maricopa Med Center,
(Number) (Full Name and Complete Address of Hospital)

2601 E Roosevelt, Phoenix, AZ.

in the field of OB-gyn from July 93 to June 1994
(Date) (Date/Anticipated Date)

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

1. Was applicant ever required to repeat any segment of training? NO If YES, which part(s)?
2. Was applicant ever placed on probation, restricted or limited? NO If YES, please attach written explanation.
3. Was there any reason not to continue applicant in the training program? NO If YES, please attach written explanation.
4. Was applicant ever known to use or misuse any chemical substance or substances which required treatment or counseling? [redacted] If YES, please attach written explanation.
5. Was applicant ever known to suffer from any mental health disorders which required treatment or counseling? [redacted] If YES, please attach written explanation.
6. Were applicant's final evaluations in every category rated satisfactory and/or above? YES If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed John Kelly MD (SEAL OF HOSPITAL)
(So indicate, if none)

Title Program Director Phoenix Integrated Residency OB-gyn

Address 2601 E. Roosevelt Phoenix, AZ 85008 Date RECEIVED 2-7-95, 19

FEB 24 95

Revised 8/89

Phoenix Integrated Residency In Obstetrics And Gynecology at Maricopa Medical Center and St. Joseph's Hospital And Medical Center

Phoenix, Arizona

Be it known that

Ronald Alexander Yunis, M.D.

has successfully completed 12 *months of Graduate Medical Education in an*

Obstetrics and Gynecology Residency

from June 23, 1993 *to* June 22, 1994

in Testimony Whereof the undersigned have hereto affixed their signatures this 22nd *day of* June, 19 94

John V. Kelly M.D.
Program Director

Associate Program Director

Director of Medical Education
Maricopa Medical Center

Director of Medical Education
St. Joseph's Hospital and Medical Center

President, Maricopa Medical Center

President
St. Joseph's Hospital and Medical Center

FORM III

POSTGRADUATE TRAINING CERTIFICATION

TO WHOM IT MAY CONCERN:

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

Name: RONALD A. YUNIS, M.D. R. Y., M.D.
(Please Print or Type) (Signature)

Address: [redacted]
(Street) (City and State)

Date: 5/3/95

(DO NOT DETACH)

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

This is to certify that RONALD ALEXANDER YUNIS, M.D. undertook and
(Name of Applicant in Full)

satisfactorily completed a full term approved program of 11 months in the: Texas Tech University Health
(Number) (Full Name and Complete Address of Hospital)

Sciences Center, Dept. OB/GYN, 3601 4th Street, Lubbock, TX 79430

in the field of Obstetrics and Gynecology from 7/1/94 to 6/30/97
(Date) (Anticipated Date)

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

1. Was applicant ever required to repeat any segment of training? No If YES, which part(s)? _____

2. Was applicant ever placed on probation, restricted or limited? NO If YES, please attach a written explanation.

3. Was there any reason not to continue applicant in the training program? No If YES, please attach a written explanation.

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

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

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

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

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

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

Tumble

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

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

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

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

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

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

Signed D L E M Z M.D. [redacted]

Title Professor/Associate Chairman/Program Director
Texas Tech Univ Health Sciences Center

Address: 3601 4th St., Dept. OB/GYN, Lubbock, TX 79430

Date 5/5, 19 95

Revised 2/95 Reorder # IPS 40169

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

FORM III

POSTGRADUATE TRAINING CERTIFICATION

TO WHOM IT MAY CONCERN:

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Name: RONALD A. YUNIS, M.D. [signature], M.D.
(Please Print or Type) (Signature)

Address: [redacted]
(Street) (City and State)

Date: 2/12/97

(DO NOT DETACH)

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

This is to certify that Ronald Alexander Yunis, M.D., M.D. undertook and
(Name of Applicant in Full)

satisfactorily completed a full term approved program of _____ months in the: Texas Tech University Health
(Number) (Full Name and Complete Address of Hospital)
Sciences Center, Dept. OB/GYN, 3601 4th Street, Lubbock, TX 79430

in the field of Obstetrics and Gynecology from 7/1/94 to 6/30/97
(Date) (Date/Anticipated Date)

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

1. Was applicant ever required to repeat any segment of training? No If YES, which part(s)? _____

2. Was applicant ever placed on probation, restricted or limited? No If YES, please attach a written explanation.

3. Was there any reason not to continue applicant in the training program? No If YES, please attach a written explanation.

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

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

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

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

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

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

(OVER)

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

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

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

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

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

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

Signed [signature]

(SEAL OF HOSPITAL)
(So indicate if none)

Title Professor/Associate Chairman/Program Director
Texas Tech Univ Health Sciences Center

Address: 3601 4th St., Dept. OB/GYN, Lubbock, TX 79430

Date 2/20, 19 97

Revised 2/95 Reorder # IPS 40169

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

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

Diplomate Name: Ronald Alexander Yunis, MD

Date of Birth: [redacted]

Certification Date: 07/01/1994 **Certificate #:** 427522

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME PART I	Jun 1991	193 79	176 75	PASS							
Comments											
USMLE Step 2	Sep 1992	195 80	167 75	PASS							
NBME PART III	Mar 1994	405 78	315 75	PASS							

DATE: 01/19/1995

SEE OTHER SIDE FOR SCORE INFORMATION

AZ0346

This NBME *Endorsement of Certification* may include scores for Step 1 and Step 2 of the United States Medical Licensing Examination™ (USMLE™). The USMLE, established by the Federation of State Medical Boards and the NBME, is a single, uniform medical licensure examination system comprised of three Step examinations. USMLE will replace both the current Federation Licensing Examination (FLEX) and the NBME Parts I, II and III. Implementation of USMLE began with the administration of Steps 1 and 2 in 1992. The first administration of Step 3 will occur in June 1994. The NBME accepts passing scores on Parts I, II, and III as meeting the examination requirements for its certification program and the following combinations of passing scores on NBME examinations and USMLE: Part I or Step 1 **plus** Part II or Step 2 **plus** Part III or Step 3.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

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

NBME Part I and Part II Examinations June 1991 and Thereafter

The most recent total test score is reported. This score is on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

Step 1 and Step 2 of the United States Medical Licensing Examination (USMLE)

The complete USMLE examination history is given. A total test score is reported on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

All NBME Part III Examinations

The most recent total test score is reported. This score is on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Two-Digit Scores

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

EXPLANATION OF COMMENTS

For USMLE Step 1 and Step 2, this document is annotated to reflect special circumstances regarding the score report.

If you wish to obtain further information about individual examinees who have notations under "Comments," please write the NBME Supervisor of Examinee Records.

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

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

Irregular Behavior - Determination was made by the USMLE Committee on Irregular Behavior that the examinee engaged in such behavior. Irregular behavior includes all actions on the part of applicants and/or examinees, or by others when solicited by an applicant and/or examinee, that subvert or attempt to subvert the examination process.

Score Not Yet Available - Score not available pending further review and/or analysis.

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

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

SATISFACTION OF REQUIREMENTS SUMMARY

ENDORSEMENT

APPLICATION Received February 2, 1995

NAME IN FULL YUNIS RONALD ALEXANDER

Current Address [redacted]

Telephone [redacted] (Residence) (Office)

BIRTHPLACE [redacted] Date:

(City) (State) (Country)

CITIZENSHIP Check One: XXX Native ☐ Naturalized Declared Intention On

MEDICAL EDUCATION Mt. Sinai School of Medicineof the City University of New York, New York, NY 035-47
(Full Name and Location of Medical School)
M.D. Awarded: May 18, 1993 Proof Received: April 10, 1995 XX Approved

ECFMG Certificate No. Dated: Proof Received:

FORM III/photo fee paid

POSTGRADUATE TRAINING

In OBG for 12 months at Maricopa Medical Center, Phoenix, AZ
(Field of Training) (Name of Institution)
From July 1, 1993 to June 30, 1994

FORM III/photo

In OBG for 17 months at Texas Tech University Health Science Center, Lubbock, TX
(Field of Training) (Name of Institution)
From July 1, 1994 to Date 1995 (will complete 6/30/97)

In for months at
(Field of Training) (Name of Institution)
From to

In for months at
(Field of Training) (Name of Institution)
From to

In for months at
(Field of Training) (Name of Institution)
From to

AMERICAN BOARD

Of None Certificate No. Issued
(Specialty)

Of Certificate No. Issued
(Specialty)

PRACTICE Field of OBG
(Current)

SPEX EXAM: None DATE: SCORE: PROOF REC'D

FORM II

Endorsement through National Board ; No. 427522 ; Issued 7/1/94 W/E
(Certificate) (Date)

LICENSES

None ; [ ] W/E [ ] FLEX [ ] Recip. With

In TEXAS ; [ ] W/E [ ] FLEX [ ] Recip. With

In NEW YORK ; [ ] W/E [ ] FLEX [ ] Recip. With

In ; [ ] W/E [ ] FLEX [ ] Recip. With

In ; [ ] W/E [ ] FLEX [ ] Recip. With

In ; [ ] W/E [ ] FLEX [ ] Recip. With

In ; [ ] W/E [ ] FLEX [ ] Recip. With

In ; [ ] W/E [ ] FLEX [ ] Recip. With

In ; [ ] W/E [ ] FLEX [ ] Recip. With

(TUMBLE)

RONALD A. YUNIS, CONTINUED:

U.S. MILITARY OR PUBLIC HEALTH SERVICE

Served in None (Branch) From to

Honorable Discharge Received Discharge Rank

PREVIOUS PRACTICE

In	Phoenix (internship) AZ	From	June 23, 19	93 to	June 22, 19 94
In	Lubbock (residency) TX	From	July 1, 19	94 to	Date 19 95
In		From	19	to	19
In		From	19	to	19
In		From	19	to	19
In		From	19	to	19
In		From	19	to	19
In		From	19	to	19
In		From	19	to	19
In		From	19	to	19
In		From	19	to	19
In		From	19	to	19
In		From	19	to	19
In		From	19	to	19

FEES

Temporary $ Receipt # Examination $ Receipt #

Locum Tenens $ Receipt # Endorsement $ 450.00 Receipt # A063200

INVESTIGATION

AMA Approval update - 3/24/97, info same 2/21/95, Record Clear, N/D

Fed. State Board Approval update 12-21-95 info same — update 3/25/97 2/3/95, Record Clear, N/D

TEXAS Board Approval 3/10/97, current, N/D

New York Board Approval 4/28/97, current, N/D

Board Approval

Board Approval

Board Approval

Board Approval

Board Approval

Board Approval

Board Approval

Ass'n Approval

Ass'n Approval

Ass'n Approval

INTENDED LOCATION

None

jd 4/27/95

update 12-18-95 ms 5/18/95

May 2, 1997

Ronald A. Yunis, M.D.

Dear Dr. Yunis:

Congratulations! Your certificate to practice medicine in the State of Arizona, License No. 25201, issued on May 2, 1997, is enclosed with your wallet registration card for the current year.

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

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

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

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

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

Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Elaine Hugunin
Deputy Director

Enclosures

Is your RETURN ADDRESS completed on the reverse side?

SENDER: LIC

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

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

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

Consult postmaster for fee.

3. Article Addressed to:

Ronald A. Yunis, M.D.

4a. Article Number

P 562 817 712

4b. Service Type

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

7. Date of Delivery

MAY 15 1992

5. Received By: *(Print Name)*

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

6. Signature: *(Addressee or Agent)*

X

PS Form **3811,** December 1994

Domestic Return Receipt

Thank you for using Return Receipt Service.

Arizona

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

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, YUNIS RONALD ALEXANDER
WAS ISSUED LICENSE/CERTIFICATE NUMBER 201341 FOR THE PRACTICE OF MEDICINE ON 11/14/95.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: [redacted]
SCHOOL ATTENDED: MT SINAI SCHOOL MEDICINE
DATE OF GRADUATION: 05/18/93
DEGREE EARNED: MD

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

BASIS OF LICENSURE:
NAT BD CERT #427522 DATED 7/1/94
6/91-NBME PART 1: PASS
9/92-USMLE STEP 2: 80
3/94-NBME PART 3: PASS

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

CURRENTLY REGISTERED: YES REG PERIOD ENDS: 10/31/97
ADDRESS: [redacted]

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

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

SEAL

Frank Gebosky 04/11/97
PRINCIPAL CLERK

OP026 044

RECEIVED B.O.M.E.X.
APR 28 97

CUT OFF THIS STRIP

READ INSTRUCTIONS

ON REVERSE SIDE

The University of the State of New York

THIS IS TO CERTIFY THAT QUALIFICATIONS FOR PROFESSIONAL PRACTICE IN NEW YORK STATE HAVING BEEN APPROVED

THE STATE EDUCATION DEPARTMENT

HAS REGISTERED 2939600

YUNIS RONALD ALEXANDER

9328

READ INSTRUCTIONS

ON REVERSE SIDE

FOR PRACTICE IN NEW YORK STATE AS A (N)

PHYSICIAN

10/31/97
REGISTRATION PERIOD ENDS

201341-1
LICENSE/CERTIFICATE NO.

SIGNATURE OF REGISTRANT

COMMISSIONER OF EDUCATION

REGISTRATION CERTIFICATE --- NOT A LICENSE

CUT OFF THIS STRIP

CUT OFF THIS STRIP

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE

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

Sections 304 and 1008 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.

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	05-31-1999	$210.00

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3,3N,4,5	PRACTITIONER	10-30-1996

YUNIS, RONALD A MD
TEXAS TECH HEALTH SCIENCES CTR
DEPARTMENT OF OB/GYN
3601-4TH STREET
LUBBOCK, TX 79430

Form DEA-223 (8/95)

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

Certified copy of original

Cheryl J Rosbu

1/8/97

RECEIVED B.O.M.E.X.

APR 25 97

THE UNIVERSITY OF THE STATE OF NEW YORK

EDUCATION DEPARTMENT

BE IT KNOWN THAT

RONALD ALEXANDER YUNIS

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

MEDICINE AND SURGERY

IN THE STATE OF NEW YORK

IN WITNESS WHEREOF THE EDUCATION DEPARTMENT GRANTS THIS LICENSE UNDER ITS SEAL AT ALBANY, NEW YORK THIS FOURTEENTH DAY OF NOVEMBER, 1995.

PRESIDENT OF THE UNIVERSITY
AND COMMISSIONER OF EDUCATION

EXECUTIVE SECRETARY
STATE BOARD FOR
MEDICINE

LICENSE NUMBER
201341

2939600 Certified copy of original

1-8-97

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 EAST MORTEN AVENUE, SUITE #210, PHOENIX, ARIZONA 85020
(602) 255-3751

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

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

MAR 03 1997

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

NAME: YUNIS (Last) RONALD (First) ALEXANDER (Middle)
(Print or Type)

ADDRESS: [redacted]
(City) *(State)* *(Zip)*

BIRTH DATE: AUGUST 23 1967

SOCIAL SECURITY NO.: [redacted]

Medical School of Graduation and Branch Location: MOUNT SINAI SCHOOL OF MEDICINE NY, NY

Date of Graduation: MAY 1993

Physician's Signature: R. Yunis

Date signed by Physician: FEB 12, 1997

FEDERATION OF STATE MEDICAL BOARDS COMMENTS:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAR 17 1997

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

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

Texas State Board of Medical Examiners

333 Guadalupe • Tower 3 • Suite 610 • Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

ARIZONA STATE BOARD OF
MEDICAL EXAMINERS
1651 EAST MORTEN AVENUE
SUITE-210
PHOENIX, AZ 85020

MARCH 5, 1997

For: ARIZONA STATE BOARD OF MEDICAL EXAMINERS

In response to a recent request, we verify the following information:

****

Physician:	RONALD ALEXANDER YUNIS, MD
License:	K1735
Date Issued:	11-16-96
Licensed By:	Reciprocity with NEW YORK
Date of Birth:	[redacted]
Medical School:	MOUNT SINAI SCH OF MED, CITY UNIV OF NEW YORK, NEW Y
Graduation Year:	1993
Permit Expires:	05-31-97

Registration Status:

This is to certify that the above-named physician is licensed to practice medicine in Texas.

Disciplinary Status:

The board has not filed any formal complaints or statements of charges against this physician.

Investigation Status:

Not applicable.

****

If you have any further questions, please contact the Verification division.

Sincerely,

E. Vasquez

Verification Division

BOARD SEAL

RECEIVED B.O.M.E.X.
MAR 10 97

ARIZONA BOARD OF MEDICAL EXAMINERS

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

February 5, 1997

Ronald Alexander Yunis, M.D.
[redacted]

Dear Dr. Yunis:

Enclosed please find the forms required to update your application for licensure in the state of Arizona.

~~Verification~~ of licensure from the state of Texas 3/10/97
Verification of licensure from the state of New York. 4-28-97
Physician Profile from the AMA 3/24
Disciplinary Search from the Federation of State Medical Boards. 3/25
Hospital affiliation forms.
Form III Postgraduate Training Certification from Texas Tech University, 2/25
Lubbock, TX for the period July 1, 1995 to anticipated date of completion. 2/25

Please provide this Board with a list of all hospital affiliations within the past five years, excluding postgraduate training. Please advise.

If you have any questions regarding this communication, I can be reached at extension 7103.

Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Marie Slaughter
Assistant Manager, Licensing

Enclosures

ARIZONA BOARD OF MEDICAL EXAMINERS

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

January 22, 1997

Ronald A. Yunis, M.D.
[redacted]

Dear Dr. Yunis:

This will acknowledge receipt of you initial registration card.

Please be advised that your application for licensure in the state of Arizona was officially withdrawn in December 1996. One year after you were notified that your application was approved for licensure.

If it is still your desire to obtain an Arizona license, you will need to request in writing that your application be reactivated. At that time we will advise you of necessary updates.

na

Please be advised that the statutory fee of $450.00 will need to be submitted.

If you have any questions regarding this communication, I can be reached at extension 7103.

Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Marie Slaughter
Assistant Manager, Licensing

ARIZONA BOARD OF MEDICAL EXAMINERS

READ CAREFULLY - THIS CAN SAVE YOU MONEY

December 21, 1995

Ronald Alexander Yunis, M.D.
[redacted]

Dear Doctor Yunis:

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

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

Please note that the Arizona Revised Statutes further provide that each licentiate is required to renew such registration on January 1st of each year. If you want to save money and you are **not** planning to practice medicine in Arizona until **after January 1, 1996**, the enclosed card can be submitted now **with your written instructions to withhold issuance of a license until after January 1, 1996**. No license number will be assigned until the actual issuance of the license.

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

Any questions you have regarding this communication may be directed to Jacqueline Downing, Licensing Technician, at Ext. 7105. Thank you for your cooperation.

Sincerely,

BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA

Jacqueline Montgomery
Licensing Technician

Enclosures (3)

1651 East Morten, Suite 210 • Phoenix, Arizona 85020 • Telephone (602) 255-3751 • FAX (602) 255-1848
[approval.ltr]

ARIZONA BOARD OF MEDICAL EXAMINERS

PERSONAL & CONFIDENTIAL
August 11, 1995

Ronald Alexander Yunis, M.D.
[redacted]

Re: Qualifications for Licensure by Endorsement

Dear Dr. Yunis:

You have applied for an Arizona medical license by endorsement, and have taken a combination of the National Board of Medical Examiners' Licensing Examination and the United States Medical Licensing Examination.

In order to qualify for licensure by endorsement of a combination of examination scores, Arizona Revised Statutes §32-1426(b)(4) requires that an applicant successfully complete one of a combination of examinations administered between June 1, 1992 and July 31, 1995. The combinations under which you have applied (A.R.S.§32-1426(b)(4)(c)) require that you have completed each of the following examinations administered between June 1, 1992 and July 31, 1995;

* Part One of the National Board of Medical Examiners' Licensing Exam OR Step One of the United States Medical Licensing Examination, AND

* Part Two of the National Board of Medical Examiners' Licensing Examination OR Step Two of the United States Medical Licensing Examination, AND

* Part Three of the National Board of Medical Examiners' Licensing Examination OR Step Three of the United States Medical Licensing Examination OR Component Two of the Federation Licensing Examination (FLEX).

Our records indicate that you passed NBME Part One administered June, 1991; USMLE Step Two administered September, 1992; NBME Part Three in March, 1994. The NBME administered in June, 1991 is not within the time frame specified in the statutes.

At its meeting on July 21, 1995, the Board of Medical Examiners acknowledged the time limitations stated in A.R.S. §32-1426(b)(4)(c) and confirmed that the Board cannot issue licenses under that section to applicants whose examinations were not within the stated time frame. The Board did, however, direct Board staff to seek legislative changes to remove the 1992-1995 date requirements of the statute and to provide instead that the first part or step of the examination and the last part or step of the examination combination be passed within a seven (7) year period.

Should you have any further questions or need further information, please contact me at (602) 255-3751 extension 7504.

Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

MARK R. SPEICHER
Executive Director

MRS:ib

cc: Elaine Hugunin, Deputy Director
Becky Drew, Licensing Manager

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

April 28, 1995

Ronald Alexander Yunis, M.D.
[redacted]

Dear Doctor Yunis:

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

Our receipt No A063200 covering your fee deposit of $ 450.00 is enclosed. Also included with this communication is a schedule of examination dates and filing deadlines, if applicable.

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

✓ Form III Postgraduate Training Certification from Texas Tech University Health Science Center, Lubbock, TX for the period July l, 1994 to anticipated date of completion. (form enclosed) 5-22-95

✓ Enclosed, please find your Form I Medical College Certification from Mt. Sinai School of Medicine. Please attach a recent photo of yourself, and send it to Mt. Sinai again, and ask them to affix their seal partially across the photo.We must have verification with your photograph. 6/9/95

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

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

Your application is being processed routinely and you will be advised as to the Board's decision relative to the granting of an Arizona license.

If you have any questions regarding this communication, please contact me at Ext. 7105 Thank you for your cooperation.

Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OFARIZONA

Jackie Downing
Licensing Technician

[DEFICIEN.LTR]

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 E. Morten Avenue, Suite 210, Phoenix, AZ 85020

KINDLY COMPLETE AND SEND TO THE FEDERATION OF STATE MEDICAL BOARDS AT THE ADDRESS BELOW.

DATE: 12/6/94

Coordinator, Disciplinary Data Bank
Federation of State Medical Boards
6000 Western Place, Suite #707
Fort Worth, Texas 76107

RECEIVED
FEB 01 1995
BY

The ARIZONA BOARD OF MEDICAL EXAMINERS requests a disciplinary search concerning the following individual:

YUNIS	RONALD	ALEXANDER
(LAST)	(FIRST)	(MIDDLE)

NAME: [redacted]

ADDRESS: [redacted]

City, State and Zip [redacted]

Date of Birth [redacted]

Social Security Number

MOUNT SINAI SCHOOL OF MEDICINE, NY, NY
Medical School of Graduation and Branch Location

5/93/93
Date of Graduation

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

FEB 02 1995

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

Please mail the response to the following:

Arizona Board of Medical Examiners
1651 East Morten Avenue, Suite 210
Phoenix, Arizona 85020

R. J.
Signature

HOSPITAL AFFILIATION

Dear Sir:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the Medical Staff Office in each hospital where I have held privileges, consultation or teaching appointments during the five years preceding my application. this is your authority to release any information in your files of record, favorable or otherwise, DIRECTLY to the ARIZONA BOARD OF MEDIAL EXAMINERS, 1651 East Morten Avenue, Suite #210, Phoenix, Arizona 85020.
Your early response will be appreciated.

NAME: RONALD A. YUNIS ,M.D. R. J. ,M.D.
(Signature)

ADDRESS [redacted]

(DO NOT DETACH)

1. What privileges were extended to the applicant? **house staff**

2. DATES: FROM: **7/1/94** TO: **present**

3. Were any limitations imposed on such privileges? **No**
   If YES, please explain.

4. Were staff privileges ever removed or restricted? **No**
   If YES, please explain.
   Derogatory Information, if any

Names of other hospital affiliations, if known (list name, city and state):

1.

2.

3.

4.

Comments, if any: **Residents are employed by TTUHSC and are not credentialed by hospitals. They have house staff privileges only.**

Director, Medical Staff: **Nita Hardin**
Hospital Name: **Texas Tech University Health Sciences Center**
Address: **3601 - 4th Street** City & State: **Lubbock, Texas 79430**
Date: **February 21, 1997** Signature: Nita Hardin
Nita Hardin
(Typed or Printed)

STAMP OR SEAL OF HOSPITAL
IF NO SEAL, PLEASE INDICATE

RECEIVED B.O.M.E.X.
FEB 27 97

ARIZONA STATE BOARD OF MEDICAL EXAMINERS

MEDICAL AGENCY OF EMPLOYMENT

Dear Sir:

In applying for a license to practice medicine in the State of Arizona, the Medical Board requires this form to be completed by the medical agency wherein I am currently or have veen employed for the past five years. This is your authority to release any information in your files, favorable or otherwise, **DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 1651 EAST MORTEN AVENUE, SUITE#210, PHOENIX, ARIZONA 85020.**

NAME: RONALD ALEXANDER YUNIS M.D. R. Y. M.D.
(signature)

ADDRESS: [redacted] DATE: 12/6/94

CITY [redacted] STATE [redacted] ZIP [redacted]

The Physician named above stipulates his/her whereabouts as including employment with your medical agency. We would appreciate your comments as to current or prior employment, together with any information you may possess, favorable or otherwise, regarding the doctor's employment. If additional space is required, please use the back of this form.

NAME OF MEDICAL AGENCY: Texas Tech Univ Health Sciences Center
ADDRESS: Dept. OB/GYN, 3601 4th Street, Lubbock, TX 79430

Dates of employment with your agency: FROM: 7/1/94 TO Present
(MONTH & YEAR)

Names, location and dates of each hospital/office/clinic wherein the doctor was/is assigned: _____

Were doctor's services performed in a satisfactory manner? Y/N, If no, please explain _____

Derogatory information, if any: _____

Name and address of other source wherein additional information may be obtained, if applicable _____

Your name and title: Daniel E. McGunegle, M.D., Program Director
Signature: D. E. McG

Date: February 2, 1995

[AGENCY SEAL OR STAMP]
PLEASE INDICATE IF NONE

Training

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

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

HOSPITAL AFFILIATION

Dear Sir:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the Medical Staff Office in each hospital where I have held privileges, consultation or teaching appointments during the five years preceding my application. This is your authority to release any information in your files of record, favorable or otherwise, DIRECTLY to the ARIZONA BOARD OF MEDICAL EXAMINERS, 1651 E. Morten Avenue, Suite 210, Phoenix, Arizona 85020. Your early response will be appreciated.

NAME: RONALD ALEXANDER YUNIS, M.D. R. Y., M.D.
(SIGNATURE)

ADDRESS [redacted]

==========

(DO NOT DETACH)

1. What privileges were extended to the applicant? Resident privileges in Ob/Gyn
2. DATES: FROM: 1 July 94 TO: 1 Feb 95
3. Were any limitations imposed on such privileges? NO
   If YES, please explain.
4. Were staff privileges ever removed or restricted? NO
   If YES, please explain.
   Derogatory Information, if any

Names of other hospital affiliations, if known (list name, city and state):

1.
2.
3.
4.

Comments, if any:

Director, Medical Staff: Daniel E. McGunegle, M.D.

Hospital Name: University Medical Center

Address: 602 Indiana City & State: Lubbock, TX

Date: February 2, 1995 Signature: D E McG

Daniel E. McGunegle, M.D.
(TYPED OR PRINTED)

STAMP OR SEAL OF HOSPITAL
IF NO SEAL, PLEASE INDICATE

Training

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

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

TO: HOSPITAL DIRECTOR OF MEDICAL STAFF

Ronald A Yuris, M.D. is applying for a license to practice medicine in the State of Arizona. In compliance with the licensing requirements of the Arizona Medical Practice Act, we are requesting that you complete the back of this form and return it DIRECTLY to the ARIZONA BOARD OF MEDICAL EXAMINERS, 1651 E. Morten Avenue, Suite 210, Phoenix, Arizona 85020. Your early response will be appreciated.

CHAPTER 13 - MEDICINE & SURGERY
Arizona Revised Statutes
ARTICLE I
BOARD OF MEDICAL EXAMINERS

§32-1403. Powers and duties of the board; compensation; immunity

A. The primary duty of the board is to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional practitioners of allopathic medicine through licensure, regulation and rehabilitation of the profession in this state. The powers and duties of the board include:

1. Ordering and evaluating physical, psychological, psychiatric and competency testing of licensed physicians and candidates for licensure as may be determined necessary by the board.

2. Initiating investigations and determining on its own motion if a doctor of medicine has engaged in unprofessional conduct or provided incompetent medical care or is mentally or physically unable to engage in the practice of medicine.

ARTICLE 2
LICENSING

§32-1422. Basic requirements for granting a license to practice medicine

A. An applicant for a license to practice medicine in this state pursuant to this article shall meet each of the following basic requirements:

1. Graduate from an approved school of medicine or receive a medical education which the board deems to be of equivalent quality.

2. Successfully complete an approved twelve month hospital internship, residency or clinical fellowship program.

3. Have the physical and mental capability to safely engage in the practice of medicine.

4. Have a professional record which indicates that the applicant has not committed any act or engage in any conduct which would constitute grounds for disciplinary action against a licensee under this chapter.

5. Have a professional record which indicates that the applicant has not had a license to practice medicine refused, revoked, suspended or restricted in any way by any state, territory, district or country for reasons which relate to his ability to competently and safely practice medicine.

B. The board may require the submission of such credentials or other evidence, written and oral, and make such investigation as it deems necessary to adequately inform itself with respect to an applicant's ability to meet the requirements prescribed by this section, including a requirement that the applicant for licensure undergo a physical examination, a mental evaluation and an oral competence examination and interview, or any combination thereof, as the board deems proper.

Mark R. Speicher

MARK R. SPEICHER, EXECUTIVE DIRECTOR
ARIZONA BOARD OF MEDICAL EXAMINERS

NOV 15 1994

YUNIS, Ronald

(FOR OFFICE USE ONLY)

PRELIMINARY QUESTIONNAIRE

(ENDORSEMENT)

THIS IS NOT AN APPLICATION FOR LICENSE

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

Full Legal Name: ~~Yunis~~ RONALD (FIRST) ALEXANDER (MIDDLE) YUNIS (LAST)

Current Office Address: DEPT. OB/GYN Texas Tech UHSC 3601 4th St. ~~Lubbock Tx 79430~~

City: LUBBOCK State: TX Zip Code: 79430 Area Code: 806 Phone: 743-2340

Current Residence Address: [redacted]

City [redacted] State: [redacted] Zip Code: [redacted] Area Code: [redacted] Phone: [redacted]

MEDICAL SCHOOL: Name: MOUNT SINAI SCHOOL OF MEDICINE 035-47

City and State: N.Y., N.Y. Date of Degree: 5/93

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

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

5TH PATHWAY PROGRAM: U.S. Medical School: _____

HOSPITAL: _____ City: _____ State: _____

Term: Started: _____ (MONTH AND YEAR) Completed: _____ (MONTH AND YEAR)

INTERNSHIP: (List U.S. & Canadian only) **HOSPITAL:** MARICOPA MEDICAL CENTER

_____ City: PHOENIX State: AZ.

Term: Started: 8/93 (MONTH AND YEAR) Completed: 8/94 (MONTH AND YEAR) OK

RESIDENCY/FELLOWSHIP: (List U.S. & Canadian only) **HOSPITAL:** TEXAS TECH UNIVERSITY HEALTH SCIENCES CTR City: Lubbock State: Tx OK

Term: Started: 8/94 (MONTH AND YEAR) Completed: Continuing. (MONTH AND YEAR)

Specialty Field: Obstetrics & Gynecology.

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

_____ City: _____ State: _____

Term: Started: _____ (MONTH AND YEAR) Completed: _____ (MONTH AND YEAR)

Specialty Field: _____

FOR OFFICE USE ONLY

INFORMATION FORM FORWARDED _____ 19__

RECIPROCITY - EXAM APPLICATION FORWARDED 12/11 19 94

Green

APPLICATION & FORMS I II III IV V VI VII NB2 AMA FS 2-HOSP 1-MAE

BOARD

DEC 5 1994

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

TEACHING HOSPITAL: _____

City: _____ State: _____

Medical School Affiliate: _____

Term: Started: _____ (MONTH AND YEAR) Completed: _____ (MONTH AND YEAR)

Specialty Field: _____

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

FOREIGN MEDICAL SCHOOL GRADUATES: ECFMG Cert. No. _____ Date Issued: _____

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

Please indicate which examinations you have succesfully passed:

NATIONAL BOARD	USMLE	FLEX (taken after 1/1/85)
Part I 6/91 (date)	Step I _____ (date)	Comp. I _____ (date)
Part II 9/92 (date) →	Step II 9/92 (date)	Comp. II _____ (date)
Part III 3/94 (date) →	Step III 3/94 (date)	

FLEX examination taken prior to January 1, 1985 _____ (date)

Were grades achieved all in one sitting? X (yes) _____ (no)

State Board exam? ____ Name of State _____ License No. _____ Date iss. _____

LMCC (Canadian) _____ Cert. No. _____ Date iss._____

SPECIAL PURPOSE EXAMINATION:

(SPEX): _____ (STATE) Date SPEX examination taken: _____ (MONTH & YEAR)

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

Are you a Diplomate of any of the *American* Medical Specialty Boards? Yes _____ No _____ .

If "Yes", which Board(s)? _____

Have you completed the educational requirements for any of the *American* Medical Specialty Boards?

Yes _____ No _____ . If "Yes", which Board(s)? _____

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

(1) _____ (2)_____ (3)_____ (4)_____ (5) _____

(6) _____ (7)_____ (8)_____ (9)_____ (10) _____

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

MARICOPA MEDICAL CENTER Phoenix, Az

ST JOSEPH'S HOSPITAL Phoenix, Az

Texas Tech University Health Sciences Center Lubbock Tx.

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

PRACTICE: City & State Where You Now Practice: _____

Date Above Practi[redacted]Was Established: _____

U.S. CITIZENSHIP:

(X) Birth
( ) Naturalization
( ) Declaration of Intention
( ) Hold Permanent Immigrant Status
( ) Awaiting Quota Assignment

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

MILITARY (United States Only):

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

Dates of Active Duty: _____ Type of Discharge: _____

Has any formal disciplinary or rehabilitation action including reprimand, censure, probation, restriction, limitation, suspension or revocation been taken against your license in any State/ Province? Yes _____ No X

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

If "Yes", indicate State/ Province _____

Reason for action and action taken: _____

(NOTE: Attach separate sheet, if necessary)

Have you ever been convicted of Medicare/ Medicaid fraud? Yes _____ No X

If "Yes", when? _____

_____ Where? _____

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

If "Yes", when? _____

Where? & By Which Agency? _____

Have you ever been involved in any malpractice matter which resulted in a settlement or judgement against you in excess of $20,000? Yes _____ No X

Have you ever had hospital privileges revoked; denied; suspended or restricted in any way? Yes _____ No X

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

(NOTE: Attach separate sheet, if necessary)

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

SIGNATURE: R. J. , M.D. DATE: 11/20/94

REQUIREMENTS FOR ARIZONA LICENSURE

FOR GRADUATES OF APPROVED MEDICAL SCHOOLS (United States or Canada)

A. Must have successfully completed 12 months hospital internship, residency or fellowship program which was approved by the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, the Royal College of Physicians and Surgeons of Canada or any similar body in the United States or Canada whose function is that of approving training programs.

B. Must have successfully passed a complete written examination conducted by any state, territory or district of the United States, or be certified by the National Board of Medical Examiners as having passed either, all three parts of the National Board examination or all three Steps of the United States Medical Licensing examination, or be certified by the Licensing Medical Council of Canada, or passed the Federation Licensing Examination.

Note: If applicant's written examination was the FLEX exam taken prior to January 1, 1985, must have been taken in one sitting and must have achieved a FLEX weighted average of at least 75.

If FLEX was taken after January 1, 1985, both Component I and Component II must have been passed within a 5 year period and must have received at least a 75 in each Component.

If applicant's written examination was the USMLE exam, all three Steps must have been taken within a 7 year period and must have received at least a 75 in each Step.

The following combinations of examinations (hybrids) are acceptable if taken from June 1, 1992 to July 31, 1995:

1.) Parts One and Two of the NBME *AND* either Step Three of the USMLE or Component II of FLEX.

2.) FLEX Component I *AND* Step Three of the USMLE.

3.) *EACH* of the following:

i.) NBME Part One or Step One of the USMLE

ii.) NBME Part Two or Step Two of the USMLE

iii.) NBME Part Three or Step Three of the USMLE or Component II of FLEX

C. An applicant seeking licensure by endorsement based on successful passage of a written examination which precedes by more than 10 years his application for licensure in this state, shall take and successfully complete a Special Purpose Examination (SPEX). An applicant who fails the SPEX exam 3 times, shall prove to the Board that he/she successfully completed an additional twelve months approved postgraduate training before retaking SPEX.

D. Must file an application for licensure by either Endorsement or Endorsement & SPEX.

E. Must pay all fees.

F. Must contact the Federation of State Medical Boards at 6000 Western Place, Suite 707, Fort Worth, Texas 76107, to request that all FLEX and USMLE scores be sent to this office. The Federation charges $40.00 for this service. (Scores must be received in this office before any application will be forwarded to the applicant.)

FOR GRADUATES OF UNAPPROVED ALLOPATHIC MEDICAL SCHOOLS

in addition to the above requirements, the following must be met:

1.) Hold a standard certificate issued by the Educational Council for Foreign Medical Graduates, complete a Fifth Pathway program, or complete thirty-six months as a full-time Assistant Professor or higher position in an approved school of medicine.

2.) Successfully complete an approved twenty-four month hospital internship, residency or clinical fellowship program in addition to A. above, for a total of thirty-six months, unless the applicant successfully completed a Fifth Pathway program, or has served as a full-time Assistant Professor or higher position at an approved school of medicine.

Note: The above examination requirements are statutorily set and cannot be waived by the Board.

Revised: 7/93

National Board of Medical Examiners

of the

United States of America

Ronald Alexander Yunis, M.D.

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

Diplomate of the National Board of Medical Examiners

Attest

Chairman of the Board

President of the Board

Philadelphia, Pa.

July 1, 1994

Certificate No.

427522

TEXAS TECH
UNIVERSITY
HEALTH SCIENCES CENTER

School of Medicine
Department of Obstetrics and Gynecology
3601 4th Street
Lubbock, Texas 79430
(806) 743-2335

YUNIS, Ronald

To Whom it concerns:

I am writing to request the proper forms to apply for my Arizona medical license. I completed my internship last year in Ob/Gyn at Maricopa Medical Center (Phoenix) and I am currently a PGY-2 at Texas Tech (Lubbock, Tx).

I graduated from the Mount Sinai School of Medicine in 5/93 and I have passed parts 1, 2, and 3 of the NBME taken 6/91, 9/92, and 3/94 (all first available exam dates- I'm not exactly sure on the dates).

Please forward the appropriate forms to me at:

Dr. Ronald A. Yunis

Thank you,

R. Yunis.

Ronald Yunis, M.D.

Sent PQ, AMG
11/15/94

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 30, 2016

Ronald Alexander Yunis M.D.
2023 W Bethany Home Rd
Phoenix, AZ 85015

Re: Ronald Alexander Yunis MD
Case # MD-16-0883A

Dear Dr. Yunis:

You were previously provided notice that a complaint had been filed against your Arizona medical license. The Board's staff has reviewed the complaint referenced above, 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 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514
Telephone: 480-551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmdboard.org • Email: questions@azmdboard.org

March 4, 2005

PERSONAL and CONFIDENTIAL
Ronald A. Yunis, M.D.
[redacted]

RE: D.S. vs. Ronald A. Yunis, M.D.
Case No. MD-04-0650

Dear Dr. Yunis:

The review of the case listed above has determined that there is no violation of the Medical Practice Act. Accordingly, I have dismissed the case. A.R.S. §32-1405 (C)(21).

In cases other than Arizona Medical Board initiated investigations, 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,

Timothy C. Miller, J.D.
Executive Director

TCM/lmh

Enclosure

cc: Investigative File
Licensing File

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

RECEIVED
JUN 28 2006
ARIZONA MEDICAL BO.
BUSINESS OPERATION

PHYSICIAN NAME: Ronald A. Yunis, MD

LICENSE #: 25201 SPECIALTY: OB/Gyn

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			
1108 W. Indian School Rd				Phoenix/AZ/85013			
Phone Number				Fax Number		E Mail	
(602) 415-1900				(602) 415-0985			
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			

***** List any additional locations on the reverse side of this form and place a check mark here: ☐

Physician's Signature: [signature] Date: 6/28/06

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 or MasterCard

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

ENTERED

ARIZONA MEDICAL BOARD

1740 W Adams St, Suite 4000, Phoenix , AZ 85007
Telephone: (480) 551-2700 - Website: www.azmd.gov

RECEIVED
MAY - 9 2019

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Ronald Alexander Yunis, MD

MD LICENSE #: 25201 **SPECIALTY:** Ob/Gyn.

Renewal Registration ($150) (Renewal & fee must come together postmarked by 6/30)

- Confirm ALL locations below where you will be dispensing prescription drugs, devices and controlled substances. (For each location, place a check mark to verify address and schedule of drugs dispensed from each location are correct)
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.
- Blank form attached to add additional locations

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

2023 W Bethany Home Rd
Phoenix, AZ 85015

Prescription Only Drugs
Prescription Devices

Dispensing location information correct Copy of DEA attached Remove this location

1615 E Osborn Road
Phoenix, AZ 85016

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

Dispensing location information correct Copy of DEA attached Remove this location

Physician's Signature: _____ Date: 5/7/19

ENTERED

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	05-31-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	04-19-2017

YUNIS, RONALD MD
2023 W BETHANY HOME RD
PHOENIX, AZ 85015-0000

CONTROLLED SUBSTANCE/REGULATED CHEMICAL 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.

Form DEA-223/511 (9/2016)

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:

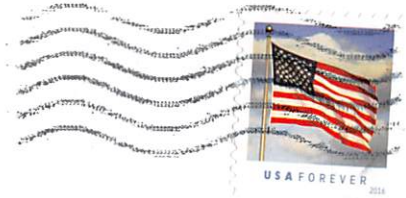
Drug Enforcement Administration
P.O. Box 2639
Springfield, VA 22152-2639

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

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

Ronald A. Yunis, MD
2023 W Bethany Home Rd
Phoenix, AZ 85015

PHOENIX AZ 852
07 MAY 2019 PM 11 L



Az. Medical Board
1740 W. Adams St.
Ste #4000
Phoenix, Az 85015

85007-266400

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 **

RECEIVED JAN 10 2019 ARIZONA MEDICAL BOARD

PHYSICIAN NAME: Ronald Yunis MD

LICENSE #: 25201 SPECIALTY: OB | 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:**

Street Address				City/State/Zip Code			
1615 E Osborn Road				Phoenix AZ 85016			
Phone Number				Fax Number		[redacted]	
602 462 5559				602 667 6608			
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			
2023 W Bethany Home Rd.				Phoenix, AZ 85015			
Phone Number				Fax Number		[redacted]	
602-415 1900				602 415-0985			
Schedule II Drugs	✓	Schedule III Drugs	✓	Prescription-Only Drugs	✓	Nubain	✓
Schedule IV Drugs	✓	Schedule V Drugs	✓	Prescription Devices	✓		

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

Physician's Signature: [signature] Date: 1/9/19

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

[redacted]

[redacted]

283/637 1:8

YUNIS, RONALD MD
1615 E OSBORN RD
PHOENIX, AZ 85016-7121

[redacted]

[redacted]

10030579 2/004143-1/1-0

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	05-31-2021	$731
SCHEDULES	**BUSINESS ACTIVITY**	**ISSUE DATE**
2,2N, 3,3N,4,5	PRACTITIONER	12-17-2018

YUNIS, RONALD MD
1615 E OSBORN RD
PHOENIX, AZ 85016-7121

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]	05-31-2021	$731
SCHEDULES	**BUSINESS ACTIVITY**	**ISSUE DATE**
2,2N, 3,3N,4,5	PRACTITIONER	12-17-2018

YUNIS, RONALD MD
1615 E OSBORN RD
PHOENIX, AZ 85016-7121

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.

Form DEA-223 (9/2016)

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmdboard.org

Pd
cc

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MAY 20 2005

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Ronald Yunis, MD

LICENSE #: 25201 **SPECIALTY:** OB/Gyn

CHECK ONE: ☐ Initial Registration ($200) ☒ Renewal Registration ($100)

- 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: Clinica Lorena **DEA # FOR THIS LOCATION:** [redacted]

Street Address				City/State/Zip Code			
3243 W. Thomas Rd							
Phone Number				**Fax Number**		**E Mail**	
602 415 1900				602 415-0985			
Schedule II Drugs	X	Schedule III Drugs	X	Prescription-Only Drugs	X	Nubain	
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices	X		

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			

***** List any additional locations on the reverse side of this form and place a check mark here: ☐

Physician's Signature: _____ **Date:** 5/19/05

Initial registration fee: $200.00 *per physician* **Renewal registration fee: $100.00 *per physician***

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

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

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmdboard.org

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RECEIVED
MAY - 5 2004
By

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: Ronald Alexander Yunis, MD

LICENSE #: 25201 **SPECIALTY:** 03/6yr

CHECK ONE: ☐ Initial Registration ($200) ☒ Renewal Registration ($100)

- 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			
3243 W. Thomas Rd.				Phoenix, AZ 85017			
Phone Number				**Fax Number**		**E Mail**	
602-415-1900				602 415-1900			
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**			

***** List any additional locations on the reverse side of this form and place a check mark here: ☐

Physician's Signature: [signature] **Date:** 5/3/04

Initial registration fee: $200.00 *per physician* **Renewal registration fee: $100.00 *per physician***

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

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

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

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

8/23/2019

Ronald Alexander Yunis

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

General Questions

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

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

No

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

No

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

No

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

No

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

No

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

No

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

No

8) This question has been deleted

[redacted]

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

[redacted]

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

No

Physical/Mental Health and Substance Abuse Questions

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

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

[redacted]

2) This question has been deleted.

[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	No	Yes		

Practice Address

Clinica Latina Healthcare Group
2023 W Bethany Home Rd
Phoenix AZ, 85015
Phone: (602) 415-1900
Fax: (602) 415-0985

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

Clinica Latina Healthcare Group
2023 W Bethany Home Rd
Phoenix AZ, 85015
[redacted]
Contact: Adriana Garcia
Contact Phone: [redacted]
Contact Email:
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 penalty 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.

cc

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JUL 31 2017
ARIZONAMEDICALBOARD

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

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

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 profiles can be accessed at www.azmd.gov.

1. **First Name:** Ronald **Initial:** A **Last Name:** Yunis

License Number: AZ 25201

ADDRESS INFORMATION

Practice Address: This is the practice/office location 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:** Ronald A. Yunis, MD

Address: 2023 W. Bethany Home Rd **City:** Phoenix **State:** AZ **Zip:** 85015

Phone: 6024151900 **Fax:** 6024150985 ***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 but the Board may occasionally send relevant news and information to you via email.

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

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

Primary Email Address: [redacted]

ENTERED

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	
	☐ 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 naturalization 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 provided 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 naturalization 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: Ronald **Last Name:** Yunis

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JUL 31 2017

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.

Full Name (print):	Ronald	**Signature:**	
License number:	AZ 25201	**Date:**	07/30/2017

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]

The purpose of the confidential question is to allow the Board to determine the applicant's current fitness to practice medicine. The mere fact of treatment, monitoring or participation in a support group is not, in itself, a basis of which admission is denied; the Board routinely licenses individuals who demonstrate personal responsibility and maturity in dealing with fitness issues. The Board encourages those applicants who may benefit from assistance to seek it. The Board may limit or deny licensure to applicants whose ability to function is impaired in a manner relevant to the practice of medicine at the time the licensing decision is made or to applicants who demonstrate a lack of candor by their responses. This is consistent with the public purpose that underlies the licensing responsibilities assigned to the Arizona Medical Board and to the applicants seeking licensure.

NOTE: In the event that the response to any of the questions is "Yes", you must fully explain 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: Ronald **Last Name:** Yunis

13. 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: Ronald **Last Name:** Yunis

Signature of Applicant: [signature] Date: 7/30/17

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

August 3, 2015

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

Dr. Ronald Yunis
1108 W Indian School Rd Ste A
Phoenix, AZ 85013-3107

[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 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 Assistant
Sara.Bachmann@azmd.gov

From: [redacted]
To: Sara Bachmann
Subject: Re: Arizona Medical Board-Renewal deficient
Date: Monday, August 03, 2015 11:56:50 PM
Attachments: [redacted]

Sorry, Sara never saw any request for such document.
Let me know if this will suffice.

Dr Yunis

On Mon, Aug 3, 2015 at 8:11 AM, Sara Bachmann <Sara.Bachmann@azmd.gov> wrote:

> Please see attached deficiency letter.
>
> ***Sara Bachmann***
>
> ***Licensing Renewal Coordinator***
>
> ***Sara.Bachmann@azmd.gov***
>
> ***Phone: 480-551-2718***
>
> ***Fax: 480-551-2704***
>
>

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

7/15/2015

Ronald Alexander Yunis

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	No	Yes		

Practice Address

(Directory Address)
Clinica Latina Healthcare Group
1108 W Indian School Rd Ste A
Phoenix AZ, 85013-3107
Phone: (602) 415-1900
Fax: (602) 415-0985

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

Clinica Latina Healthcare Group
1108 W Indian School Rd Ste A
Phoenix AZ, 85013-3107
[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.

Arizona Medical Board: License Renewal Questions

Ronald Yunis 2013 License # 25201 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 prescr be, 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

Ronald	Yunis	2013	License # 25201	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]

CC RECEIVED
AUG 23 2011
AZ MEDICAL BOARD

BIENNIAL MD LICENSE RENEWAL APPLICATION

(Please Type in Spaces Provided)

508

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

☐ **$850** if postmarked 30 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.

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

First Name: Ronald **Initial:** A **Last Name:** Yunis

License Number: AZ25201

ADDRESSES:

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

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

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

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

Practice Name: Clinica Latina Healthcare Group

Office Address: 1108 W Indian School Rd Ste A **City:** Phoenix **State:** AZ **Zip:** 85013

Office Phone: +1 (602) 415-1900 **Office Fax:** +1 (602) 415-0985

Mailing Address: 1108 W Indian School Rd Ste A **City:** Phoenix **State:** AZ **Zip:** 85013

Email: [redacted]

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.*

ENTERED

AMERICAN BOARD OF MEDICAL SPECIALTY (ABMS) CERTIFICATIONS AND FIELDS OF PRACTICE: Please review and correct the fields of practice and ABMS board certification information as shown on your profile. Only certifications from the American Board of Medical Specialties will be shown. Select the 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)
Obstetrics & Gynecology	☐ Yes ☒ No	☒ Yes ☐ No	
	☐ 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 a qualified registered alien.
IF YOUR LEGAL STATUS HAS CHANGED SINCE YOUR LAST RENEWAL OR YOU HAVE A NEW DOCUMENT WITH CURRENT VALID DATES, PLEASE INCLUDE A COPY WITH YOUR RENEWAL. The Board will contact you prior to mailing of your wallet card if we do not have a copy of your legal status on file.

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: Ronald **Initial:** A **Last Name:** Yunis

License Number: AZ25201

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: Ronald **Initial:** A **Last Name:** Yunis

Signature: [signature] **License Number:** AZ25201

Questions?

CC

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 25201 **Renewal Fee:** ~~$500~~ $850 (If postmarked 30 days after due date)

Name: Ronald A. Yunis, MD

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER
1108 W. Indian School Rd Ste A
Phoenix, AZ 85013

Phone #: 602 415 1900 **Fax #:** 602 415 0985

E-Mail: [redacted]

MAILING ADDRESS
1108 W Indian School Rd
Ste A
Phoenix AZ 85013

RECEIVED
AUG 28 2009
AZ MEDICAL BOARD

HOME ADDRESS [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)
OBG	N	Y	

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) 8/28/2009 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: Ronald A. Yunis, MD License Number: 25201

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.

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

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

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

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

Name: Ronald A Yunis, MD License Number: 25201

Signature: _____ PAGE 3

ARIZONA MEDICAL BOARD
2007 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 25201 Ronald A. Yunis, MD **Renewal Fee: $500 $850** (if postmarked after **09/23/2007**)

CURRENT INFORMATION Please review and make corrections as necessary ™	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 1108 W Indian School Rd Phoenix AZ 85013-3107	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** Suite A
Phone #: (602) 415-1900 **Fax #:** (602) 415-0985 **E-Mail:**	**Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS [redacted]	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** **E-Mail:** **Mobile #:**	**Phone #:** **Fax #:** **E-Mail:** **Mobile #:** [redacted] (Optional)

RECEIVED
AUG 21 2007
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

	Certified?	Practicing?
OBG	N	Y

Make corrections if necessary
INTIALS REQUIRED

	Certified?	Practicing?	Expiration Date	Initials Required

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

REQUEST FOR CHANGE IN LICENSE STATUS:

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

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

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

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

8/15/07

25201 Ronald A. Yunis, MD

SEE REVERSE SIDE

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.

INITIALS REQUIRED _____

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

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

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

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

25201 Ronald A. Yunis, MD **INITIALS REQUIRED** _____

DEC 13 2005

ARIZONA MEDICAL BOARD
2005 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 25201 Ronald A. Yunis, MD **Renewal Fee: $500**

$850 (If postmarked after 09/23/2005)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 3243 W Thomas Rd Phoenix AZ 85017-5311 **Phone #:** (602) 415-1900 **Fax #:** (602) 415-0985 **E-Mail:**	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** **Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS [redacted]	**MAILING ADDRESS**
HOME ADDRESS [redacted] **Phone #** [redacted] **Fax #:** **E-Mail:**	**HOME ADDRESS** **Phone #:** **Fax #:** **E-Mail:** **Cell Phone #:** (Optional)

ENTERED

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?

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

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

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

Signature of Licensee (Signature stamp will not be accepted)

12/12/05
Date

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

Pd CC

2003 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 25201 Ronald A. Yunis, MD Renewal Fee: $500 $850 (if postmarked after 09/23/2003)

[redacted]

3243 W Thomas Rd
Phoenix AZ 85017-5311

Phone #: (602) 415-1900 Fax #: (602) 415-0985
E-Mail:

[redacted]

RECEIVED
OCT 16 2003
By

Phone #: Fax #:
E-Mail:

[redacted]

Phone #: [redacted] Fax #:
E-Mail:
Cell Phone #: (Optional)

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

	Certified?	Practicing?
OBG	N	Y

Make corrections if necessary

	Certified?	Practicing?

[redacted]

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[redacted]

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
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   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

[redacted]

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2001 and 2002, 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) 10/16/03 Date

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