ARIZONA BOARD OF MEDICAL EXAMINERS

2001 West Camelback Road, Suite 300
Phoenix, Arizona 85015
A.C. (602) 255-3751

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE THROUGH ENDORSEMENT

APR 1 4 1993

FOR BOARD USE
DO NOT USE THIS SPACE

BOMEX

APR 2 6 1993

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 Applications not fully complete within one year from date of receipt are considered withdrawn.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 — LESSER (Last) KAREN (First) BETH (Middle) (Maiden)
   (a) Other names used: None Social Security No. 067-38-3860
2. Address: Residence: [redacted] (No.) (Street) (City) (State) (Zip Code) (Phone)
   Office 101 (No.) DUPLEY ST. (Street) PROVIDENCE (City) RI (State) 02905 401-274-1122 EXT. 2546
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) Rhode Island (Specify State Board) — (Date of Application) — Granted (Result) — 8075 (Certificate No.)
   10/2/91 (Date Issued) — Credentials (Specify if by Written Examination or on Credentials)
   (b) New York (Specify State Board) — Not Available (Date of Application) — Granted (Result) — 178270 (Certificate No.)

8/13 new address:

[redacted]

NO (Answer)

NO (Answer)

NO (Answer)

NO (Answer)

YES - Revoked for non payment, reinstated per payment. (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 5'3½" weight 125 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.

OB/GYN - Internship/Residency: Columbia Presbyterian Medical Center
630 W. 168th St. NY. NY. 10032 7/87 - 6/91.
Maternal - Fetal Medicine - Fellowship: Brown University / Women + Infants Hospital
101 Dudley St. Providence RI 02906. 7/91 - 6/93

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? YES If so, which? OB/GYN. + MATERNAL-FETAL MEDICINE (WILL FINISH REQUIREMENTS 6/93)

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.

	City	State	from	to
At	NY.	NY.	7/87	6/91
At	PROVIDENCE	RI	7/91	6/93
At				
At				
At				
At				

23. In the event you are successful in obtaining a license to practice medicine by this application, have you selected a location?
YES Where? TUSCON, AZ.
Solo or in Association with? UNIVERSITY OF ARIZONA
24. What is your intended specialty practice? OB/GYN + MATERNAL-FETAL MEDICINE
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 KAREN BETH LESSER
(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 Karen Lesser, M.D.

STATE OF Rhode Island
County of Providence } ss

(NOTARIAL SEAL)

Subscribed and sworn to before me this 23rd day of April, 19 93.

Notary Signature Francine Adrienne Fadiny (Notary Public) My Commission expires June 27, 1993

FOR OFFICE USE ONLY

Application Rec'd	19	Application Processed by	CM
Application Completed	19	Application Checked by	CM
Form No. I Rec'd 4/29	19 93	Application Approved Aug. 26	19 93
Form No. II Rec'd 5/14	19 93	By	Clara McCullough
Form No. III Rec'd 5/10	19 93	License Issued Sept 10	19 93
Form No. III Rec'd	19	License No.	21758
Form No. III-A Rec'd	19		
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.

1) HOSPITAL: Women and Infants Hospital

ADDRESS: 101 Dudley St. PROVIDENCE RI 02905
City State Zip Code

DATE OF STAFF MEMBERSHIP: July 1, 1991

TYPE OF STAFF MEMBERSHIP: Fellowship training in Maternal-Fetal Medicine

2) HOSPITAL: Columbia Presbyterian Medical Center

ADDRESS: 630 W. 168th St. N.Y. N.Y. 10032
City State Zip Code

DATE OF STAFF MEMBERSHIP: July 1, 1987

TYPE OF STAFF MEMBERSHIP: Resident- OB/GYN

3) HOSPITAL: _____

ADDRESS: _____
City State Zip Code

DATE OF STAFF MEMBERSHIP: _____

TYPE OF STAFF MEMBERSHIP: _____

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: _____

BOMEX
APR 26 1993

6) MEDICAL AGENCY OF EMPLOYMENT: _____

ADDRESS: _____
City State Zip Code

DATE OF EMPLOYMENT: _____

The American Board of Obstetrics and Gynecology, Inc.

KAREN BETH LESSER

has completed the required graduate medical education in obstetrics and gynecology and has passed the written examination required by The American Board of Obstetrics and Gynecology, Inc. This physician is an ACTIVE CANDIDATE for certification and may become a Diplomate of this Board after fulfilling all requirements and passing the oral examination by December 31, 1997.

Dated June 24, 1991

Albert B. Lebre
PRESIDENT

James A. Merrill
EXECUTIVE DIRECTOR

NO. 91-8133-350269

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, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

Name: KAREN LESSER , M.D. Karen Lesser , M.D.
(Please Print or Type) (Signature)

Address: [redacted]

Date: April 19, 1993

(DO NOT DETACH)

[redacted] 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 Karen Beth Lesser
(Full Name of Student)

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

Tulane University School of Medicine on June 6 19 87 ,
(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 22 , 19 83 ; and that he/she attended

all (Number) full courses of medical lectures comprising 9 (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)? _____

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 James J Corrigan , M.D.
James J. Corrigan, Jr., M.D.

Dean Interim
President
Secretary
Registrar
of Tulane University School of Medicine

(SEAL OF COLLEGE)

Date April 23 , 1993

Address: 1430 Tulane Avenue New Orleans, Louisiana

Please return completed form DIRECT to:
Arizona Board of Medical Examiners, 2001 W. Camelback Rd., Suite 300, Phoenix, Arizona 85015

Revised 4/91

RECEIVED A.B.M.E.X.
AUG 12 93

RECEIVED A.B.M.E.X.
APR 29 93

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.

Tulane University

School of Medicine

Whereas

Karen Beth Lesser

has duly fulfilled all the requirements prescribed, therefore the degree of

Doctor of Medicine

is this day conferred with all the rights, honors, privileges, and responsibilities pertaining thereto.

In evidence thereof, *there is impressed upon this Diploma the seal of the University and the signatures of the Chairman of the Board of Administrators, the President of the University, the Chancellor of the Medical Center, and the Dean of the School of Medicine.*

Given at New Orleans, in the State of Louisiana,
June sixth, Nineteen hundred and eighty-seven.

Chairman of the Board of Administrators

President of the University

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, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

Name: KAREN LESSER, M.D. (Please Print or Type) — Karen Lesser, M.D. (Signature)

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

Date: 4/19/93

(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 Karen Lesser (Name of Applicant in Full), M.D. undertook and satisfactorily completed a full term approved program of 48 (Number) months in the: Presbyterian Hospital, (Full Name and Complete Address of Hospital) 622 West 168th Street, New York, N.Y. 10032

in the field of Obstetrics and Gynecology from 07/01/87 (Date) to 06/30/91 (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 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

Title Senior VP for Medical Affairs

Address 161 Fort Washington Ave; New York, NY Date , 19

(SEAL OF HOSPITAL) (So indicate, if none)

RECEIVED MAY 10 93

Revised 8/89

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.

COLUMBIA UNIVERSITY
IN THE CITY OF NEW YORK

THIS IS TO CERTIFY THAT

KAREN B. LESSER, M.D.

HAS SERVED AS

A POST-DOCTORAL RESIDENCY FELLOW

UNDER THE SUPERVISION OF THE DEPARTMENT OF

OBSTETRICS AND GYNECOLOGY

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS

AT

THE PRESBYTERIAN HOSPITAL

JULY 1, 1987-JUNE 30, 1991

AND HAS DISCHARGED ALL RESPONSIBILITIES WITH ABILITY AND INTEGRITY

Mortimer D. Rosen M.D.
CHAIRMAN

DEAN OF THE FACULTY
OF MEDICINE

THE PRESBYTERIAN HOSPITAL

in the
City of New York

This is to Certify that

Karen B. Lesser, M.D.

has served as

Resident in Obstetrics and Gynecology

in The Presbyterian Hospital in the City of New York to the satisfaction of the authorities and with credit
from July 1, 1987 *to* June 30, 1991

Lydia E Kess
SECRETARY, BOARD OF TRUSTEES

Courtenay C Rowe MD
DIRECTOR OF OBSTETRICS AND GYNECOLOGY

H J Boswell
PRESIDENT

THE PRESBYTERIAN HOSPITAL

in the City of New York

This is to Certify that

Karen B. Lesser, M.D.

has served as

Chief Resident in Obstetrics and Gynecology

to the satisfaction of the authorities and with credit

from July 1, 1990 *, to* June 30, 1991

H G Bolwell
PRESIDENT

Lydia E Kess
SECRETARY, BOARD OF TRUSTEES

Lawrence C Rosenn MD
DIRECTOR OF OBSTETRICS AND GYNECOLOGY

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, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

Name: KAREN LESSER, M.D. (Please Print or Type) — Karen Lesser, M.D. (Signature)

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

Date: August 15, 1993

(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 Karen Beth Lesser (Name of Applicant in Full), M.D. undertook and satisfactorily completed a full term approved program of 24 (Number) months in the: Women and Infants Hospital of Rhode Island, 101 Dudley St. Providence, RI 02905 (Full Name and Complete Address of Hospital)

in the field of Maternal - Fetal Medicine from July 1991 (Date) to June 1993 (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 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.

BOMEX AUG 24 1993

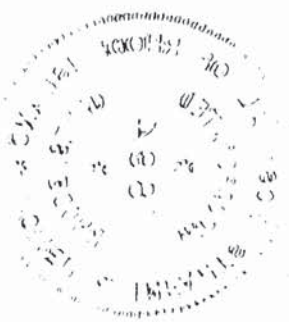
Signed Marshall W Carpenter, MD Assoc Prof. Ob Gyn (SEAL OF HOSPITAL) (So indicate, if none)

Title Director, Maternal - Fetal Medicine

Address Women + Infants Hospital 101 Dudley St. Providence RI 02905 Date 8/22, 1993

Revised 8/89

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® • 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Karen Beth Lesser, MD

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest **L. Thompson Bowles, MD, PhD**
Chairman of the Board

SEAL **Robert L. Volle, PhD**
President of the Board

Philadelphia, Pa.
07/01/88

Certificate # **347197**

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from **Tulane University School of Medicine** in **JUNE 1987** and whose birth date is [redacted] this physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/85		
Anatomy	430	76
Physiology	480	79
Biochemistry	435	76
Pathology	460	78
Microbiology	530	82
Pharmacology	435	76
Behavioral Sciences	470	79
TOTAL TEST (Minimum Passing Score 380/75)	450	77
PART II passed 04/87		
Medicine	430	79
Surgery	495	82
Obstetrics and Gynecology	560	85
Public Health and Preventive Medicine	520	83
Pediatrics	500	82
Psychiatry	440	79
TOTAL TEST (Minimum Passing Score 290/75)	485	81
PART III passed 03/88		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	505	82.3

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

SEE OTHER SIDE FOR SCORE INFORMATION

SEAL

Melanie Valente
Secretary for Certification

RECEIVED U.S.M.E.X.
MAY 14 93

05/07/93
Date

AZ1053

INTERPRETATION OF SCORES

STANDARD SCORES

Part I and Part II Examinations Passed Prior to June 1991

Total test score **and** subject scores are reported. The total test score is based on the 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 reported on a scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Part I Examination - June & September 1991 Part II Examination - September 1991 & April 1992

Only total test score is reported. The total test score is based on the total number of questions answered correctly on the entire examination. Scores are reported on a scale with a mean of 200 and a standard deviation of 20, in increments of 1.

All Part III Examinations

Only total test score is reported. The total test score is based on the total number of questions answered correctly on the entire examination. Scores are reported on a scale with a mean of 500 and a standard deviation of 100, in increments of 5.

SCALE SCORES

For all examinations, the scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

SATISFACTION OF REQUIREMENTS SUMMARY

ENDORSEMENT

APPLICATION — Received 4/26/93

NAME IN FULL — LESSER KAREN BETH (Middle)

Current Address — [redacted]

Telephone — [redacted] (Residence) (401)274-1122 x2346 (Office)

BIRTHPLACE — [redacted] (City) (State) (Country) Date: [redacted]

CITIZENSHIP — Check One: ☒ Native ☐ Naturalized Declared Intention On

MEDICAL EDUCATION — Tulane Univ. Sch. of Med., New Orleans, LA 021-01 (Full Name and Location of Medical School)
M.D. Awarded: June 6, 1987 Proof Received: 4/29/93 ☒ Approved
ECFMG Certificate No. Dated: Proof Received:

Form III/ Photo
Form III
POSTGRADUATE TRAINING

In	OBG (Field of Training)	for 48	months at	Presbyterian Hosp. New York, NY (Name of Institution)	
From	July 1, 1987			to	June 30, 1991	
(fellowship) In	MFM (Field of Training)	for 24	months at	Brown Univ./Women & Infants Hosp. Providence, RI (Name of Institution)	
From	July 1, 1991			to	June 30, 1993	
In	(Field of Training)	for	months at	(Name of Institution)	
From				to		
In	(Field of Training)	for	months at	(Name of Institution)	
From				to		
In	(Field of Training)	for	months at	(Name of Institution)	
From				to		

AMERICAN BOARD

Of Eligible (OBG) Certificate No. Issued
sub- (Specialty)
Of Eligible (MFM) Certificate No. Issued
(Specialty)

PRACTICE — Field of OBG - MFM (Current)

Form II

LICENSES

	SPEX EXAM:	DATE:	SCORE:	PROOF REC'D
Endorsement through	National Board	; No. 347197 (Certificate)	; Issued July 1, 1988 (Date)	W/E
New York	#178270	5/31/89	[ ] W/E [ ] FLEX [X] Recip. With	National Board
In Rhode Island	#8075	10/2/91	[ ] W/E [ ] FLEX [ ] Recip. With	National Baord
In			; [ ] W/E [ ] FLEX [ ] Recip. With	
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In			; [ ] W/E [ ] FLEX [ ] Recip. With	
In			; [ ] W/E [ ] FLEX [ ] Recip. With	

(TUMBLE)

U.S. MILITARY OR PUBLIC HEALTH SERVICE	Served in None		From		to	
	Honorable Discharge Received (Branch)		Discharge Rank			
PREVIOUS PRACTICE	In New York (internship/residency) NY		From July 1,	19 87	to June 30,	19 91
	In Providence (fellowship) RI		From July 1,	19 91	to June 30,	19 93
	In Providence, RI		From July	19 93	to Date	19 93
	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
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	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 # A051100		
INVESTIGATION	AMA Approval 5/3/93, Record Clear, N/D					
	New York Board Approval 5/3/93, Cert.#178270, iss. 5/31/89, End., nonrenewed, N/D					
	Rhode Island Board Approval 5/6/93, Cert.#8075, iss. 10/2/91, End., current, N/D					
	Fed State Board Approval 4/29/93, Record Clear, 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	Tucson (Univ. of Arizona)					

8/5/93 cm 8/5/93 cm

Arizona State Board of Medical Examiners
9545 E. Doubletree Ranch Road – Scottsdale AZ 85258-5514
Home Page: http://www.bomex.org E-mail: questions@bomex.org
Telephone (480) 551-2700 • Toll Free (877) 255-2212 • Fax (480) 551-2704

February 14, 2001

Karen Lesser, M.D.
U of A Health Sciences Center OB/GYN
Tucson, AZ 85724

RE: A.L. v KAREN B. LESSER, MD
Case # MD-00-0367 (Inv # 13804)

Dear Dr. Lesser:

The Arizona State Board of Medical Examiners considered the above-referenced matter during the course of the February 14-16, 2001 Regular meeting.

Following a complete and thorough review of all pertinent and available information, the Board concluded that you were not in violation of the Medical Practice Act of the State of Arizona and, accordingly, dismissed the matter.

On behalf of the Board, thank you for allowing the Board to review this matter. Should you have any questions, please contact me at (480) 551-2747.

Sincerely,

Tamara A. Turner
Board Operations Coordinator

TAT/s

cc: License File

TAB	CASE NO.	INV. #	CASE NAME	PHYSICIAN		LIC.#
81.	MD-00-0319	13755	T.C. v EMILIO M. JUSTO, MD	EMILIO	JUSTO	18595
82.	MD-00-0352	13789	B.D. v RICHARD D. ANDERSON, MD	RICHARD	ANDERSON	15344
83.	MD-00-0354	13791	R.P. v THOMAS E. JACOBSON, MD & CHANNA B. PRASAD, MD	THOMAS CHANNA	JACOBSON PRASAD	22278 14827
84.	MD-00-0367	13804	A.L. v KAREN B. LESSER, MD	KAREN	LESSER	21758
85.	MD-00-0369	13806	P.H. v MAYRA I. MELENDEZ, MD	MAYRA	MELENDEZ	26438
86.	MD-00-0371	13808	S.L. v JUDITH A. INGALLS, MD	JUDITH	INGALLS	23364
87.	MD-00-0374	13811	T.S. v NEAL W. MOGK, MD Dr. Kirschner addressed the board . His dismissal recommendation was based on the fact that he did not feel the primary care physician did anything wrong by not treating the patient earlier and that the mass was no different than what was seen earlier. **Motion: Tim Hunter, M.D. moved to dismiss the case.** **Seconded by: Honorable Becky Jordan.** **Vote: 10-0-1**	NEAL	MOGK	17321
88.	MD-00-0380	13817	J.M. v GREGORY L. LAUVER, MD	GREGORY	LAUVER	9309
89.	MD-00-0381	13818	T.C. v ANDREW L. MAESTAS, MD	ANDREW	MAESTAS	21878
90.	MD-00-0382	13819	M.R. v RAVI BHALLA, MD	RAVI	BHALLA	22399
91.	MD-00-0383	13820	J.H. v VITO R. DEL DEO, MD Investigator Monte presented the case to the board. Dr. Huber presented the medical consultants report. Tim Hunter, M.D. questioned the consultants on how the diagnoses was made. Pamela Powers, M.D. suggested it is a diagnosis of exclusion. Sharon Megdal, Ph.D noted the speaker suggested the doctor take a course in something and suggested that the board cannot send a physician to courses without disciplinary action. Edward Schwager, M.D. noted that there is nothing outside the standard of practice and there is nothing in statute that requires the doctor to be polite. **Motion: Edward Schwager, M.D. moved to dismiss the case.** **Seconded by Tim Hunter, M.D.** Pamela Powers, M.D. spoke to the motion. **Vote:9-1-1**	VITO	DEL DEO	7634

MOTION: Patrick Connell, M.D. moved to dismissed the cases that were not pulled for further discussion.
SECONDED BY Edward Schwager, M.D.
VOTE: 10-0-1

II. RECOMMENDATION FOR ADVISORY LETTER

MD-98-0829 Inv. # 12489 J.P. v KURT R. REINKE, MD
POSTPONED UNTIL FRIDAY FEBRUARY 16, 2001

MD-00-0613 Inv. # 14053 BOMEX v WILLIAM J. HALL, MD
WILLIAM HALL Lic. # 25521
MOTION: Sharon Megdal, Ph.D. moved to issue an advisory letter for potentially misleading advertising regarding specialty certifications .
SECONDED BY: Edward Schwager, M.D.
VOTE: 10-0-1

MD-00-0469 Inv. # 13907 J.K. v HENRY J. SCHULTE, MD
HENRY SCHULTE Lic. # 12400
MOTION: Richard Carmona, M.D. moved to dismiss this case as the doctor did not fall below the standard of care.
SECONDED BY: Edward Schwager, M.D.
VOTE: 10-0-1

III. NEW BUSINESS

KEVEN BROCKBANK, M.D Request for Licensure
Dr. Brockbank addressed the board
Dr. Zonis presented the medical consultants report.
Ram Krishna, M.D. reiterated the medical consultant and outside medical consultant recommendation to deny the applicants license. Edward Sattenspiel, M.D. disagreed with the outside consultant's recommendation and did not feel the doctor fell below the level of care on the first case and the second case appeared to be difficult. The last case indicated the doctor was not advised of fetal distress by the hospital. His recommendation is that the doctor be licensed. Ram Krishna, M.D. questioned Rick Albrecht if it is appropriate for the board to question the doctor if this is not a formal interview. Mr. Albrecht advised it was. Sharon Megdal, Ph.D questioned the reason for having the transciptionist taking notes. Rick Albrecht advised he saw no problem with it. Tim Hunter, M.D. requested that the doctor be sworn if he was to be questioned by the Board. The doctor was sworn in. Edward Schwager, M.D. questioned the doctor on his practice and the location he works in. Sharon Megdal, Ph.D questioned if the doctor was Board Certified.
MOTION: Edward Sattenspiel, M.D. moved that the license be granted.
SECONDED BY: Tim Hunter, M.D.
VOTE: 10-0-1

AARON W. KEMP, M.D. Request for Licensure
Dr. Kemp was present and addressed the board. The doctor was sworn in by the court reporter in the event the board wished to question the doctor.
Edward Sattenspiel, M.D. questioned the doctor on his prior medical practice.
Edward Schwager, M.D. questioned the doctor on type of practice he was in during the past 5

694-2302

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

2001 West Camelback Road, Suite 300, Phoenix, Arizona 85015

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Date: September 10, 1993

Re: License through Endorsement

Karen Beth Lesser, M.D.
[redacted]

Dear Doctor:.

Congratulations! Your certificate to practice medicine in Arizona, License No. 21758 issued on September 10, 1993 is enclosed with your pocket registration card for the current year.

Please be advised that annual reregistration is mandatory on a calendar-year basis, with notices generally being mailed to your address of record on or about November 1 of each year. Failure to reregister will result in statutory expiration of your license. It is your responsibility to keep us informed of address changes. Please note that 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."

It is also 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. Failure to do so is actionable against your license to practice. (A.R.S. §32-1451(A).

You will receive a copy of the Arizona State Medical Directory published yearly by the Board which contains the Arizona Medical Practice Act. We suggest that you familiarize yourself with such prior to establishing your practice in Arizona.

Enclosed for your information is that part of the Arizona Medical Practice Act which relates to Unprofessional Conduct, together with Continuing Medical Education information for annual reregistration and Prescription Form requirements.

Please feel free to contact this office at any time should you have any questions.

Cordially,

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

DOUGLAS N. CERF
Executive Director

DNC/am Enc. Please find extra photos not needed

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020

DATE: August 26, 1993

Karen B. Lesser, M.D.
[redacted]

RE: License through Endorsement

Dear Doctor:

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 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 Arizona Board of Medical Examiners, 1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020. The card must be in hand by Thursday of each week in order for your license to be issued the following day. DO NOT COMMENCE PRACTICE IN ARIZONA UNTIL A LICENSE NUMBER HAS BEEN ASSIGNED.

The Board publishes an annual directory of all its licentiates, which is distributed about October of each year. Information for this publication is taken from the registration card which you complete. Home addresses and telephone numbers are no published, UNLESS THIS IS THE ONLY ADDRESS WHICH YOU PROVIDE. The cut-off date for address changes for the directory is July 31 of each year. If you anticipate a move before that date, please inidcate your new address(es) with the effective date as well as your current address(es).

Thank you for your cooperation.

Cordially,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Licensing Department
Encs. 3

THE ARIZONA BOARD OF MEDICAL EXAMINERS

2001 West Camelback Road, Suite 300 • Phoenix, Arizona 85015

Telephone (602) 255-3751

August 5, 1993

Karen B. Lesser, M.D.
[redacted]

Re: License Through Endorsement

Dear Doctor:

This will acknowledge receipt of your application for a license to practice medicine in Arizona through endorsement.

Our receipt number A051100

covering your fee deposit of $ 450.00 is enclosed, with a schedule of examination dates and filing deadlines, if applicable.

To complete our processing of your application, we need to receive the following:

Form III Postgraduate Training Certification from Brown University/Womens& Infants Hospital for your fellowship training from July 1, 1991 to June 30, 1993. (form enclosed)

For your information, we have returned Form I Medical College Certification to Tulane University for completion of questions 1 through 6 on form.

NOTE: FINAL ACTION ON YOUR APPLICATION CANNOT BE TAKEN UNTIL THESE RESPONSES ARE IN YOUR FILE OF RECORD WHICH IS YOUR RESPONSIBILITY.

PLEASE BE ADVISED THAT APPLICATIONS NOT FULLY COMPLETED WITHIN ONE YEAR FROM THIS DATE, INCLUDING PARTICIPATION IN WRITTEN (FLEX/SPEX) EXAMINATIONS, IF APPLICABLE, ARE CONSIDERED WITHDRAWN.

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

Cordially,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Char McCall
Manager, Licensing Department

/cm
Enc. 2

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

2001 West Camelback, Suite 300, Phoenix, Arizona 85015, (602) 255-3751

DATE: August 5, 1993

TO: James J. Corrigan, Jr., M.D.
Tulane University School of Medicine
1430 Tulane Avenue
New Orleans, Louisiana 70112-2699

RE: Karen B. Lesser, M.D.

Dear Sir/Ms:

Please find enclosed Form I Medical College Certification from Karen B. Lesser, M.D.

Would you kindly affix response to questions 1 through 6 or explain why they cannot be answered.

and return the same to this office at an early date.

Thank you for your cooperation.

Cordially,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Char McCall
Manager, Licensing Department

/cm

Enc. 1

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

RECEIVED
APR 29 1993
BOARD OF MEDICAL LICENSURE & DISCIPLINE

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE MEDICINE. IF NEEDED, YOU MAY XEROX THIS FORM FOR ADDITIONAL COPIES.

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 EACH STATE WHEREIN I HOLD OR HAVE EVER HELD LICENSURE. THIS IS YOUR AUTHORITY TO RELEASE ANY INFORMATION IN YOUR FILES, FAVORABLE OR OTHERWISE, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 WEST CAMELBACK, SUITE #300, PHOENIX, ARIZONA 85015.

YOUR EARLY RESPONSE IS APPRECIATED.

Karen Lesser M.D.
(SIGNATURE)

NAME: KAREN BETH LESSER M.D.
(PLEASE PRINT)

ADDRESS: [redacted] (101 WORK DUDLEY ST)
PROVIDENCE RI 02906

MY LICENSE NUMBER IS: 8075

DO NOT DETACH

THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE ARIZONA BOARD OF MEDICAL EXAMINERS.

STATE OF: Rhode Island

FULL NAME OF LICENSEE: Karen B. Lesser, M.D.

GRADUATE OF: Tulane University

LICENSE No.: #8045 ISSUE DATE: 10-2-91

BY: ENDORSEMENT/RECIPROCITY WITH: NAT. BD.

BY: YOUR STATE BOARD'S WRITTEN EXAMINATION/FLEX/SPEX: No

LICENSE IS CURRENT? Yes IF NO, WHY NOT?

HAS LICENSE BEEN SUSPENDED OR REVOKED? No IF YES, WHY?

HAS LICENTIATE EVER BEEN ON PROBATION? No IF YES, WHY?

HAS LICENTIATE EVER BEEN REQUESTED TO APPEAR BEFORE YOUR BOARD? No

IF YES, WHY?

DEROGATORY INFORMATION, IF ANY No

COMMENTS IF ANY

SIGNED: Milton W. Hamolsky TITLE Chief Adm. Officer

STATE BOARD Bd of Med. Lic. & Disc.

DATE: 29 1993

[BOARD SEAL]

(PLEASE USE REVERSE SIDE FOR COMMENTS)

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, LESSER KAREN B
WAS ISSUED LICENSE/CERTIFICATE NUMBER 178270 FOR THE PRACTICE OF MEDICINE ON 05/31/89.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: [redacted]
SCHOOL ATTENDED: TULANE UNIVERSITY
DATE OF GRADUATION: 06/06/87
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 #347197 DATED 7/1/88

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

CURRENTLY REGISTERED: NO REG PERIOD ENDS:
ADDRESS: [redacted]

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

I FRANCES HARRIS, 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

REGENTS SEAL

Frances Harris by R. Dumby
PRINCIPAL CLERK

04/28/93

OP026 054

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

2001 West Camelback, Suite 300, Phoenix, Arizona 85015, (602) 255-3751

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

DATE: April 19, 1993

RECEIVED
APR 22 1993

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

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

LESSER	KAREN	BETH
(LAST)	(FIRST)	(MIDDLE)

NAME:

[redacted]

ADDRESS:

[redacted]

City, State and Zip

[redacted]

Date of Birth

[redacted]

Social Security Number

TULANE UNIVERSITY

Medical School of Graduation and Branch Location

6/1987

Date of Graduation

Please mail the response to the following:

Arizona Board of Medical Examiners
2001 West Camelback Road, Suite 300
Pheonix, Arizona 85015

Signature

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN.

APR 27 1993

James R. Winn, M.D.

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

RECEIVED
APR 29 93

HOSPITAL AFFILIATIO

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 BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

NAME: KAREN LESSER ,M.D. Karen Lesser M.D.
(SIGNATURE)

ADDRESS [redacted]

.....

(DO NOT DETACH)

1. What privileges were extended to the applicant? Obstetrics & Gynecology House Staff

2. DATES: FROM: July 1, 1987 TO: June 30, 1991

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: Robert M. Lewy, M.D., Sr. VP for Medical Affairs
Hospital Name: The Presbyterian Hospital in the City of NY
Address: 161 Fort Washington Avenue, City & State: New York, NY
Date: Signature: X
(WRITTEN)

Robert M. Lewy, M.D.
(TYPED OR PRINTED)

STAMP OR SEAL OF HOSPITAL
IF NO SEAL, PLEASE INDICATE

RECEIVED B.O.M.E.X.
MAY 10 93

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

2001 West Camelback, Suite 300, Phoenix, Arizona 85015, (602) 255-3751

TO: HOSPITAL DIRECTOR OF MEDICAL STAFF

Karen B. Lesser, 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 BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

CHAPTER 13 - MEDICINE & SURGERY

Arizona Revised Statutes

ARTICLE 1
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 engaged 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.

DOUGLAS N. CERF, EXECUTIVE DIRECTOR for the
BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

(OVER)

HOSPITAL AFFILIATI

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NAME: KAREN LESSER ,M.D. Karen Lesser M.D.
(SIGNATURE)

ADDRESS: [redacted]

(DO NOT DETACH)

1. What privileges were extended to the applicant? applicant was advised; they do not have staff privileges

2. DATES: FROM: 1 July 91 TO: 30 June 93

3. Were any limitations imposed on such privileges? —
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: Howard R. Cousins, MD Chief of Obgyn

Hospital Name: Women & Infants Hosp of RI

Address: 101 Dudley St City & State: Prov RI

Date: 20 April 93 Signature: Howard R. Cousins
(WRITTEN)

Howard R Cousins MD
(TYPED OR PRINTED)

~~STAMP OR SEAL OF HOSPITAL~~
~~IF NO SEAL, PLEASE INDICATE~~ NO SEAL

RECEIVED A.B.M.E.X.
APR 23 93

2001 West Camelback, Suite 300, Phoenix, Arizona 85015, (602) 255-3751

TO: HOSPITAL DIRECTOR OF MEDICAL STAFF

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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.

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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 engaged 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.

Douglas N. Cerf

DOUGLAS N. CERF, EXECUTIVE DIRECTOR for the
BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

(OVER)

MAR 3 0 1993

Lesser, Karen
(FOR OFFICE USE ONLY)

PRELIMINARY QUESTIONNAIRE

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, 2001 West Camelback Road, Suite 300, Phoenix, Arizona 85015. PLEASE *PRINT* ALL INFORMATION.

Full Legal Name: KAREN (FIRST) BETH (MIDDLE) LESSER (LAST)

Current Office Address: Women + Infants Hospital, Division of Maternal-Fetal Medicine
101 Dudley Street

City: PROVIDENCE State: RI Zip Code: 02905 Area Code: 401 Phone: 274-1122 Ext. 2346

Current Residence Address: [redacted]

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

MEDICAL SCHOOL: Name: TULANE UNIVERSITY

City and State: NEW ORLEANS, LA Date of Degree: 6/87

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: COLUMBIA PRESBYTERIAN MEDICAL CENTER City: NEW YORK State: NY

Term: Started: JULY, 1987 (MONTH AND YEAR) Completed: June, 1988 (MONTH AND YEAR)

RESIDENCY: (List U.S. & Canadian only) HOSPITAL: COLUMBIA PRESBYTERIAN MEDICAL CENTER City: NEW YORK State: NY

Term: Started: JULY, 1988 (MONTH AND YEAR) Completed: JUNE, 1991 (MONTH AND YEAR)

Specialty Field: OB/GYN

RESIDENCY: (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 _____ 19__

APPLICATION & FORMS I II III III-A IV

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APR 12 93

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

TEACHING HOSPITAL: BROWN UNIVERSITY / WOMEN + INFANTS HOSPITAL

City: PROVIDENCE State: RI

Medical School Affiliate: BROWN UNIVERSITY

Term: Started: JULY, 1991 (MONTH AND YEAR) Completed: JUNE, 1993 (MONTH AND YEAR)

Specialty Field: MATERNAL - FETAL MEDICINE (Fellowship - Clinical Instructor)

(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.

State Board Exam? ____ Name of State _____ Cert. No. _____ Date Issued: _____

National Board Exam? Yes Cert. No. 347197 Date Issued: 1988

LMCC (Canada)? _____ Cert. No. _____ Date Issued: _____

FLEX Exam *prior to January 1, 1985?* ____ Did you receive a minimum grade of seventy percent (70%) in each **DAY** of the Examination? Yes ____ No ____.

If "Yes", were FLEX grades obtained in one sitting? Yes ____ No ____.

FLEX Exam *after January 1, 1985?* ____ Did you receive a minimum grade of seventy-five percent (75%) in each, Component I and Component II? Yes ____ No ____.

Date Component I was taken: _____ (MONTH & YEAR) Date Component II was taken: _____ (MONTH & YEAR)

SPECIAL PURPOSE EXAMINATION (SPEX): _____ Date SPEX examination was taken: _____ (MONTH & YEAR)

Did you receive a minimum grade of seventy-five percent (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) New York (2) Rhode Island (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.: _____

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

PRACTICE: City & State Where You Now Practice: Fellowship - Providence, RI

Date Above Practice Was Established: July, 1991

CITIZENSHIP:

(✓) 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: _____, M.D. DATE: 4/8/93

SOCIAL SECURITY NO.: [redacted]

REGULAR LICENSURE. Regular licenses to practice medicine in the State of Arizona may be offered through Written Examination or Endorsement or Endorsement With SPEX Examination; the Applicant being qualified for the method of entrance by education, postgraduate education, experience or practice to the extent required by Arizona Revised Statutes.

WRITTEN EXAMINATION. Arizona offers the FLEX Examination to qualified candidates. (**NOTE:** Arizona accepts the results of the FLEX Examination taken in these United States for endorsement purposes; however, we cannot present the FLEX Examination for other jurisdictions, nor permit Arizona candidates to partake of the FLEX Examination elsewhere.)

An Applicant must obtain a grade of **seventy percent (70%)** or more on *each day* of the Examination and a **weighted average of seventy-five percent (75%)** or more on the complete FLEX Examination taken *prior* to January 1, 1985.

The successful passage of a FLEX Examination prior to January 1, 1985 must be achieved at one sitting.

An Applicant must obtain a score of **seventy-five percent (75%)** in each Component I and Component II on the FLEX Examination taken *after* January 1, 1985. The successful passage of both Components must be achieved within a three-year period.

ENDORSEMENT and/or SPEX EXAMINATION. Endorsement is offered to otherwise eligible Applicants upon successful passage of a written examination administered by another State, Territory or District of the United States, the Medical Council of Canada, or the Applicant is certified by the National Board of Medical Examiners. An Applicant seeking licensure based upon another jurisdiction's examination, shall establish to the satisfaction of the Arizona Board of Medical Examiners that the examination is substantially equivalent to the examination required by the Arizona Board of Medical Examiners, and that the Applicant's score on the examination was equal to the score required by the State of Arizona for licensure by examination.

If said examination or certificate was more than **ten (10)** years preceding the application, the Applicant *must* submit to a SPEX Examination. NOTE: Arizona accepts the results of the SPEX Examination taken in these United States for licensure pursuant to ARS §32-1426(C). SPEX score must be 75% or better.

FIFTH PATHWAY PROGRAM. If a Fifth Pathway Program was completed as part of postgraduate training, the Arizona Board of Medical Examiners requires completion of one academic year of supervised clinical training under the direction of an ap

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Revised: 3/90

National Board of Medical Examiners

of the

United States of America

BOMEX
APR 26 1993

Karen Beth Lesser, 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 L. Thompson Bowles M.D.
Chairman of the Board

Robert L. Volle
President of the Board

Philadelphia, Pa.
July 1, 1988

Certificate No.
347197

ARIZONA MEDICAL BOARD
2003 BIENNIAL MD LICENSE RENEWAL APPLICATION

294828

AZ MD Lic#: 21758 Karen B. Lesser, MD **Renewal Fee: $500** **$850** (if postmarked after **01/05/2004**)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/ PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** U Of A Health Sciences Center dept Of Ob/Gyn po Box 245078 1501 N Campbell Tucson AZ 85724-0002 **Phone #:** (520) 626-2124 **Fax #:** (520) 626-5115 **E-Mail:**	**OFFICE ADDRESS/ PRINCIPAL PLACE OF BUSINESS** **Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS U Of A Health Sciences Center dept Of Ob/Gyn po Box 245078 1501 N Campbell Tucson AZ 85724-0002	**MAILING ADDRESS**
HOME ADDRESS [redacted] **Phone #:** [redacted] **Fax #:** **E-Mail:**	**HOME ADDRESS** **Phone #:** **Fax #:** **E-Mail:** **Cell Phone #:** (Optional)

RECEIVED NOV 12 2003 By

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

	Certified?	Practicing?
MFM	Y	Y
OBG	Y	Y

Make corrections if necessary

Certified?	Practicing?

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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

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

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Other than in Arizona, are you currently under investigation by any medical board or peer review body? ☐ Yes ☑ No
2. Other than in Arizona, since your last renewal have you had a medical license disciplined resulting in revocation, suspension, limitation, restriction, probation, voluntary surrender or cancellation during an investigation? (**see instructions on back**) ☐ Yes ☑ No
3. Since your last renewal have you had hospital privileges revoked, denied, suspended or restricted? (**see instructions**) ☐ Yes ☑ No
4. Since your last renewal, have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? (**see instructions**) ☐ Yes ☑ No
5. Since your last renewal, have you had the authority to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered or revoked by a federal or state agency? (**see instructions**) ☐ Yes ☑ No
6. Within the last 5 years, have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine? (**see instructions**) [redacted]
7. Do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication?
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. If malpractice cases are reported, please include: the case number, venue, plaintiff name, and attorney names/addresses/phone numbers.

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 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] 10/13/03

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

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

ARIZONA MEDICAL BOARD
2005 BIENNIAL MD LICENSE RENEWAL APPLICATION

Paid 335209

AZ MD Lic#: 21758 Karen B. Lesser, MD Renewal Fee: **$500** **$850** (if postmarked after 01/05/2006)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** U Of A Health Sciences Center dept Of Ob/Gyn po Box 245078 1501 N Campbell Tucson AZ 85724-0002 **Phone #:** (520) 626-2124 **Fax #:** (520) 626-5115 **E-Mail:**	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** **Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS U Of A Health Sciences Center dept Of Ob/Gyn po Box 245078 1501 N Campbell Tucson AZ 85724-0002	**MAILING ADDRESS**
HOME ADDRESS [redacted] **Phone #:** [redacted] **Fax #:** **E-Mail:**	**HOME ADDRESS** **Phone #:** **Fax #:** **E-Mail:** **Cell Phone #:** (Optional)

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AMERICAN BOARD CERTIFICATIONS AND FIELDS OF PRACTICE:

	Certified?	Practicing?
OBG	Y	Y
MFM	Y	Y

Make corrections if necessary

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

	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)

10/11/05
Date

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

ARIZONA MEDICAL BOARD CR 379508

2007 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 21758 Karen B. Lesser, MD **Renewal Fee: $500 $850** (if postmarked after **01/05/2008**)

CURRENT INFORMATION Please review and make corrections as necessary ™	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** U Of A Health Sciences Center dept Of Ob/Gyn po Box 245078 1501 N Campbell Tucson AZ 85724-0002	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**
Phone #: (520) 626-2124 **Fax #:** (520) 626-5115	**Phone #:** **Fax #:**
E-Mail:	**E-Mail:**
MAILING ADDRESS U Of A Health Sciences Center dept Of Ob/Gyn po Box 245078 1501 N Campbell Tucson AZ 85724-0002	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:**	**Phone #:** **Fax #:**
E-Mail:	**E-Mail:**
Mobile #:	**Mobile #:** (Optional)

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OCT 22 2007
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

	Certified?	Practicing?
OBG	Y	Y
MFM	Y	Y

Make corrections if necessary
INTIALS REQUIRED

	Certified?	Practicing?	Expiration Date	Initials Required

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

REQUEST FOR CHANGE IN LICENSE STATUS:

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

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

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

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

21758 Karen B. Lesser, MD

SEE REVERSE SIDE

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

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

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

21758 Karen B. Lesser, MD

INITIALS REQUIRED _____

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 21758 **Renewal Fee:** $500 / $850 (if postmarked 30 days after due date)

[redacted]

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER
U of A Health Sciences Center
Dept of OB/Gyn
PO 245078
1501 N. Campbell – Tucson, AZ 85724
Phone #: 520 626 2424 **Fax #:** 520 626 5115
E-Mail:

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AZ MEDICAL BOARD

MAILING ADDRESS (REQUIRED)
U of A Health Sciences Center
Dept of OB/Gyn
PO 245078
1501 N. Campbell Ave
Tucson, AZ 85724

HOME ADDRESS (REQUIRED)
[redacted]

Phone # [redacted]
Mobile #:

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:
Only certifications from ABMS will be shown in your profile on the website. Please indicate expiration date or lifetime certificate.

Field of Practice Code (see attached form for code)	ABMS Certified? (Y/N)	Practicing? (Y/N)	Expiration Date (or indicate lifetime certificated)
OBG	y	y	1'
MFM	y	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] 11/6/09

Signature of Licensee (Signature stamp will not be accepted) 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: Karen B. Lessel License Number: 21758

Signature: _____

CONFIDENTIAL
Physician Health Program

1. **Since your last renewal have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?**
2. **Are you now being treated or since your last renewal have you been treated for a drug or alcohol addiction or participated in a rehabilitation program?** *If in a confidential program in another state see explanation below.
3. **Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice?**

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

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

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

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

(THIS SECTION INTENTIONALLY LEFT BLANK)

Name: Karen B. Lassey, MD License Number: 21758

Signature: _____

BIENNIAL MD LICENSE RENEWAL APPLICATION

(Please Type in Spaces Provided)

RECEIVED
OCT 18 2011
AZ MEDICAL BOARD

☒ **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: Karen **Initial:** B. **Last Name:** Lesser

License Number: 21758

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: U of A Dept. of OB/GYN

Office Address: 1501 N. Campbell Ave. **City:** Tucson **State:** AZ **Zip:** 85724

Office Phone: +1 (520) 626-6174 **Office Fax:** +1 (520) 626-0961

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

Email:

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

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

ENTERED

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

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

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
Obstetrics	☑ Yes ☐ No	☑ Yes ☐ No	12-31-11
Maternal & Fetal Medicine	☑ Yes ☐ No	☑ Yes ☐ No	12-31-11
	☐ 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: Karen **Initial:** B. **Last Name:** Lesser

License Number: 21758

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: Karen **Initial:** B. **Last Name:** Lesser

Signature: [signature] **License Number:** 21758

Questions?

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

October 28, 2015

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

Dr. Karen Lesser
U of A Dept of OB/GYN
1501 N Campbell
PO Box 245078
Tucson AZ 85724-0002

[redacted]

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

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

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

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

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

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

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

D. A person whose license has expired may reapply for a license to practice medicine as provided in this chapter.

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

Tiffany Thornhill
Arizona Medical Board
Licensing Renewal Coordinator
Tiffany.Thornhill@azmd.gov

ARIZONA MEDICAL BOARD
MD RENEWAL
CONFIDENTIAL QUESTION ADDENDUM

RECEIVED
NOV 16 2015
ARIZONA MEDICAL BOARD

Revised10/20/2015

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

Questionnaire

1. Since 2009, Have you been found guilty or entered into a plea of no contest to a felony, a misdemeanor involving moral turpitude, or an alcohol or drug related offense in any state?

[redacted]

2. Have you received treatment within the last five years for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narcotic or a physical, mental, emotional, or nervous disorder or condition that currently affects your ability to exercise the judgement and skills of a medical professional? If so, provide the following:

   A.) A detailed description of the use, disorder, or condition; and

   B.) An explanation of whether the use, disorder, or condition is reduced or ameliorated because you receive ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating.

   C.) A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.

[redacted]

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

Full Name (print): Karen Lesser **Signature:** [signature]

Date: 11/10/15

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

THE UNIVERSITY OF ARIZONA
College of Medicine

Obstetrics & Gynecology
P.O. Box 245078
Tucson, AZ 85724-5078

U.S. POSTAGE PITNEY BOWES
ZIP 85721 $ 000.48[5]
02 1W
0001389374 NOV 13 2015

Ob/Gyn
2450003 OPS

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

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

10/9/2015

Karen Beth Lesser

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	Maternal & Fetal Medicine (Obstetrics & Gynecology)	Yes	Yes		
Specialty 2	Obstetrics & Gynecology	Yes	Yes		

Practice Address

(Directory Address)
U Of A Dept Of Ob/Gyn
1501 N Campbell P O Box 245078
Tucson AZ, 85724-0002
Phone: (520) 626-6124
Fax: (520) 626-0961

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

U Of A Dept Of Ob/gyn
1501 N Campbell P.O. Box 245078
Tucson AZ, 85724-0002

[redacted]**alid address, if you have one.**

CME Audit Information

Dates	Type of CME Activity	# of Credit Hours
11/14/2013	ACOG - Maintence of Certification Part II MFM assignments	30
11/27/2014	ACOG - Maintence of Certificaiton Part II MFM assignements	30

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.

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

11/14/2017

Karen Beth Lesser

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	Maternal & Fetal Medicine (Obstetrics & Gynecology)	Yes	Yes		
Specialty 2	Obstetrics & Gynecology	Yes	Yes		

Practice Address

U Of A Dept Of Ob/gyn
1501 N Campbell P.O. Box 245078
Tucson AZ, 85724-0002
Phone: (520) 626-6174
Fax: (520) 626-0961

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

U Of A Dept Of Ob/gyn
1501 N Campbell P.O. Box 245078
Tucson AZ, 85724-0002

[redacted]

Contact:
Contact Phone:
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.