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

FOR BOARD USE
DO NOT USE THIS SPACE FEB 21 1989

BOMEX

MAR 24 1989

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 14 to 18 weeks.

Applications not fully complete within one year from date of receipt, including participation in an oral examination, if applicable, are considered withdrawn.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).
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 name and address of all of the following:
   (a) The secretary of the county medical society where you practiced for the three years prior to filing this application, and
   (b) All of 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 from date of graduation from medical school to the present, with specific month and year listed for each location. 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 fifteen years preceding the filing of this application, are required to submit to oral examination in their specialty field of practice.
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, 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 • Miller (Last) Husin (First) Stephen (Middle)
   (a) Other names used: [redacted] Social Security No. [redacted]
2. Address: Residence: [redacted] (No.) (Street) (City) (State) (Zip Code) (Phone)
   Office _____ (City) (State)
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) Massachusetts (Specify State Board) 7/18/87 (Date of Application) Granted/Exp 7/18/89 (Result) 57763 (Certificate No.)
   ? 7/87 (Date Issued) on Credentials (Specify if by Written Examination or on Credentials)
   (b) _____ (Specify State Board) _____ (Date of Application) _____ (Result) _____ (Certificate No.)
   _____ (Date Issued) _____ (Specify if by Written Examination or on Credentials)
5. Have you ever had an application for a license to practice medicine denied or rejected by another state/province licensing Board? No (Answer)
6. Have any actions, restrictions, or limitations ever been imposed on you while participating in any type of training program? No (Answer)
7. Have you ever been charged with a violation of any statute, rule or regulation of any domestic or foreign governmental agency? No (Answer)
8. Has there been any action initiated against you by or through any medical board or association? No (Answer)
9. Have you ever had a medical license revoked; suspended; limited; restricted; placed on probation; voluntarily surrendered or cancelled during an investigation or in lieu of disciplinary action; or entered into a consent agreement or stipulation? No (Answer)

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

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

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

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

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

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

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

Note: In the event the response to any of the questions numbered 5 through 16 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 be submitted to this Board.

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

(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 5-11 weight 190 color of eyes BROWN color of hair BROWN

19. List Internships, Residency and Fellowship training — chronologically showing institution, address and type of program, and dates. Attach separate listing if needed.

PGY I Tufts Affiliated Hospitals (TAH) in OB/GYN, 90 Cushing Ave Boston, MA 02125 7/85-6/86
PGY II T.A.H in OB/GYN " 7/86-6/87
PGY III T.A.H in OB/GYN " 7/87-6/88
PGY IV T.A.H. in OB/GYN " 7/88-6/89

20. Are you American Board certified? Eligible Specialty OB/GYN

21. Have you completed the educational requirements for any of the American medical specialty boards? If so, which? OB/GYN

22. Exact whereabouts and nature of practice from date of graduation from medical school to the present, with specific MONTH and YEAR listed for each. No period unaccounted for is allowed. Attach separate listing if needed.

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

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

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

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

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

23. In the event you are successful in obtaining a license to practice medicine by this application, have you selected a location?

Yes Where? TUCSON, AZ

Solo or in Association with? Currently considering several opportunities in TUCSON

24. What is your intended specialty practice? OB/GYN

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

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

STATE OF _____

County of _____ } ss

The applicant HUGH STEPHEN MILLER

(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 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 Hugh Stephen Miller, M.D.

(NOTARIAL SEAL)

Subscribed and sworn to before me this 22nd day of March 19 89

Notary Signature K. Bernice McNeel (Notary Public) My Commission expires 3/26/93

BOMEX

MAR 2 4 1989

FOR OFFICE USE ONLY

Application Rec'd	19	Application Processed by	ef
Application Completed	19	Application Checked by	
Form No. I Rec'd	3/9 19 89	Application Approved	Apr 26 19 89
Form No. II Rec'd	3/6 19 89	By	
Form No. III Rec'd	3/6 19 89	License Issued	5-12 19 89
Form No. III Rec'd	N/A 19	License No.	18753
Form No. III Rec'd	N/A 19		
Form No. IV. Rec'd	N/A 19		
Investigation Completed	19		

Application withdrawn _____ (Date)

Refund must be claimed by _____ (Date)

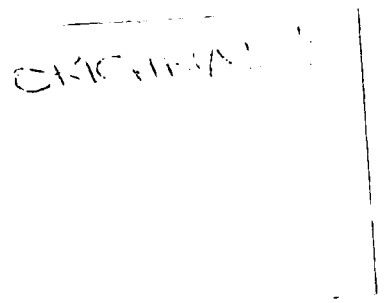
Warrants issued _____ (Numbers and Dates)

Warrants mailed _____ (Date)

Warrants cashed _____ (Date)

MEDICAL AGENCY OF EMPLOYMENT

UPHAMS CORNER HEALTH CENTER, BOSTON, MA_____



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: HUGH STEPHEN MILLER , M.D. Hugh Miller , M.D.
(Please Print or Type) (Signature)

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


Hugh Miller

2/25/89

(DO NOT DETACH)

n with a current photograph of the applicant shall be forwarded to and completed by an officer of the medical school dical degree. Please indicate to your medical school that this completed form must be returned to the Arizona Board of ners.

This is to certify that Hugh Stephen Miller
(Full Name of Student)

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

Tufts University School of Medicine on May 19 19 85 ,
(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 31 , 19 81 ; and that he/she attended 38 (Number) full courses of medical lectures comprising 1 (Number) months each as verified by the attached certified copy of his/her transcripts. Please see enclosed grade card and Dean's Letter of recommendation.

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 evaluations in every category rated satisfactory and/or above? yes If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed Barbara A. Chernow M.D.

Dean / President / Secretary / Registrar of Tufts University School of Medicine

(SEAL OF COLLEGE)

Date March 2 19 89

Address: 145 Harrison Avenue, Sackler 2, Boston, MA 02111

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

BOMEX

Revised 7/88

BOMEX MAR 0 1989

APR 14 1989

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: HUGH STEPHEN MILLER , M.D. Hugh Miller , M.D.
(Please Print or Type) (Signature)

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

Date: 2/25/89

(DO NOT DETACH)

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

This is to certify that Hugh Stephen Miller , M.D., undertook and
(Name of Applicant in Full)

satisfactorily completed a full term approved program of 48 months in the: ~~Tufts University Affiliated Program~~
(Number) (Full Name and Complete Address of Hospital)

in Ob-Gyn, 90 Cushing Ave., Boston , Ma 02125

in the field of Obstetrics and Gynecology from 7-1-85 to 6-30-89
(Date) (Date)

and that said program was approved for post graduate training during that period by the Council on Medical Education and Hospitals of the American Medical Association, or the Canadian Medical Association. 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 counselling? [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 evaluations in every category rated satisfactory and/or above? yes If NO, please attach certified photocopy of evaluation, together with written explanation.

BOMEX MAR 6 1989

Signed Charles Y. Kawada, M.D.

Charles Y. Kawada, M.D.

Title ~~Program Director~~

no seal
(SEAL OF HOSPITAL)
(So indicate, if none)

Address ~~90 Cushing Ave., Boston, Ma. 02125~~ Date ~~February 27~~, 19 ~~89~~.

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

Hugh S. Miller, 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 C. WILLIAM DAESCHNER, JR., M.D.
Chairman of the Board

SEAL EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa.
07/01/86

Certificate # 317432

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 TUFTS U SCHOOL MEDICINE in MAY 1985 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 09/83		
Anatomy	405	75
Physiology	425	76
Biochemistry	540	83
Pathology	440	77
Microbiology	440	77
Pharmacology	435	76
Behavioral Sciences	355	71
TOTAL TEST (Minimum Passing Score 380/75	425	76
PART II passed 09/84		
Internal Medicine	420	78
Surgery	335	75
Obstetrics and Gynecology	430	79
Public Health and Preventive Medicine	365	75
Pediatrics	305	73
Psychiatry	330	75
TOTAL TEST (Minimum Passing Score 290/75	330	75
PART III passed 03/86		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75	335	76.1
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		75.7

*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.

Melanie Valente
Secretary for Certification
03/02/89

SEAL

Date

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

SATISFACTION OF REQUIREMENTS SUMMARY

ENDORSEMENT

APPLICATION Received March 24, 1989

NAME IN FULL MILLER HUGH STEPHEN

Current Address [redacted]

Telephone (617) 436-8600 ext 294 (Office)

BIRTHPLACE [redacted] **Date:**

CITIZENSHIP (City) (State) (Country) Check One: ☒ Native ☐ Naturalized Declared Intention On

MEDICAL EDUCATION

Tufts University School of Medicine Boston, MA 024-07
(Full Name and Location of Medical School)

M.D. Awarded: May 19, 1985 Proof Received: 3/9/89 ☒ Approved

ECFMG Certificate No. Dated: Proof Received:

Form III

In OBG for 45 months at Tufts Univ. Affil. Prog.in OBG Boston, MA
(Field of Training) (Name of Institution)
From July 1, 1985 to Date '89(will comp 6/30/89)

POSTGRADUATE TRAINING

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

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

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

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

AMERICAN BOARD

Of NONE Certificate No. Issued
(Specialty)

Of Certificate No. Issued
(Specialty)

PRACTICE

Field of OBG
(Current)

Form II

Endorsement through National Board ; No. 317432 ; Issued 7/1/86 W/E
(Certificate) (Date)

Massachusetts#57763, 6/3/87 ; [ ] W/E [X] Reciprocity With National Board

LICENSES

In ; [ ] W/E [ ] Reciprocity With

In ; [ ] W/E [ ] Reciprocity With

In ; [ ] W/E [ ] Reciprocity With

In ; [ ] W/E [ ] Reciprocity With

In ; [ ] W/E [ ] Reciprocity With

In ; [ ] W/E [ ] Reciprocity With

In ; [ ] W/E [ ] Reciprocity With

In ; [ ] W/E [ ] Reciprocity With

(TUMBLE)

U.S. MILITARY OR PUBLIC HEALTH SERVICE	**Served in** NONE (Branch)		**From**	**to**	
	Honorable Discharge Received		**Discharge Rank**		
PREVIOUS PRACTICE	**In** Boston(residency)MA		**From** July 1	1985 to Date	19 89
	In		**From**	19 to	19
	In		**From**	19 to	19
	In		**From**	19 to	19
	In		**From**	19 to	19
	In		**From**	19 to	19
	In		**From**	19 to	19
	In		**From**	19 to	19
	In		**From**	19 to	19
	In		**From**	19 to	19
	In		**From**	19 to	19
	In		**From**	19 to	19
	In		**From**	19 to	19
FEES	**Temporary $**	**Receipt #**	**Examination $**	**Receipt #**	
	Locum Tenens $	**Receipt #**	**Endorsement $** 450.00	**Receipt #**	A 029174
INVESTIGATION	**AMA Approval**	3/9/89, record clear, N/D			
	Massachusetts	**Board Approval**	3/10/89, cert# 57763, iss 6/3/87, End, current, N/D		
	Fed State	**Board Approval**	3/3/89, record clear, N/D		
		Board Approval			
		Board Approval			
		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				

ct 3/29/89

[redacted]

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: 2/25/89

RECEIVED

Coordinator, Disciplinary Data Bank
Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

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

MILLER HUGH STEPHEN
Name: (Last) (First) (Middle)

[redacted]
Address

[redacted]
City, State and Zip

[redacted]
Date of Birth

[redacted]
Social Secruity Number

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN
MAR - 1 1989
Bryant L. Galusha M.D.
BRYANT L. GALUSHA, M.D.
EXECUTIVE DIRECTOR

TUFTS UNIVERSITY SCHOOL OF MEDICINE
Medical School of Graduation and Branch Location

6/85
Date of Graduation

Please mail the response to the following:

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

file w/ yellow sheet

Hugh Miller MD
Signature

FEB 03 1989

(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: HUGH (FIRST) STEPHEN (MIDDLE) MILLER (LAST)

Current Office Address: 90 CUSHING AVE

City: Boston State: MA Zip Code: 02125 Area Code: 617 Phone: 436-8600 Ext 294

Current Residence Address: [redacted]

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

MEDICAL SCHOOL: Name: TUFTS SCHOOL OF MEDICINE / OK 024-07

City and State: BOSTON, MA Date of Degree: 5/85

If transferred from other medical school, please indicate:

5TH PATHWAY PROGRAM

HOSPITAL: City: State:

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

INTERNSHIP: (List U.S. & Canadian only) HOSPITAL: TUFTS AFFILIATED OB/GYN HOSPITALS

City: BOSTON State: MA OK

Term: Started: 7/1/85 (MONTH AND YEAR) Completed: 6/30/86 (MONTH AND YEAR) CYR OK

RESIDENCY: (List U.S. & Canadian only) HOSPITAL: TUFTS AFFILIATED OB/GYN HOSPITALS

City: BOSTON State: MA

Term: Started: 7/1/86 (MONTH AND YEAR) Completed: 6/30/89 (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:

(NOTE: Attach separate list for additional Residency and/or Fellowship)

FOR OFFICE USE ONLY

INFORMATION FORM FORWARDED 19__

GREEN: RECIPROCITY - EXAM APPLICATION FORWARDED 2-21 1989

BOMEX FEB 14 1989

APPLICATION & FORMS I II III IV V VI VII (NBME) AMA. FedSt. 1 Lic. 1 IMAGE

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

CLINICAL WRITTEN EXAMINATION:

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

National Board Exam? yes Cert. No. 317432 Date Issued: 7/1/86

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

FLEX Exam *prior to January 1, 1985?* ____ Did you receive a 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%)? yes

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

If "Yes", which Board(s)? Junior Fellow of ACOG.

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) MA (2) _____ (3) _____ (4) _____ (5) _____

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

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

Uphams Corner Health Center, Boston, MA IMMÉ

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

PRACTICE: City & State Where You Now Practice: Boston, MA – in Residency

Date Above Practice Was Established: _____

CITIZENSHIP:

(✓) Birth ( ) Hold Permanent Immigrant Status

( ) Naturalization ( ) Awaiting Quota Assignment

( ) Declaration of Intention

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

MILITARY (United States Only):

( ) Army ( ) Air Force

( ) Navy ( ) Marine Corps

( ) USPHS ( ) Coast Guard

Dates of Active Duty: _____

Type of Discharge: _____

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

If "Yes", indicate State/Province _____

Reason for action and action taken: _____

_____

(NOTE: Attach separate sheet, if necessary)

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

If "Yes", when? _____

_____ Where? _____

Have your prescription/dispensing/or administration abilities ever been restricted or modified by a government agency? Yes ____ No ✓

If "Yes", when? _____

Where? & By Which Agency? _____

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

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

_____

(NOTE: Attach separate sheet, if necessary)

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

SIGNATURE: Hugh Miller MD, M.D. DATE: 2/9/89

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 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).

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 approved school of medicine in the United States.

Revised: 8/88

N.M. and A.K.H. (Patient: A.K.H.) vs. Kathern Plenge, M.D., (N-Phoenix) Inv. #8874 **CD#27**

Following review and discussion of all pertinent and available information, it was moved by Dr. Krishna, seconded by Dr. Guyette, and unanimously carried that this complaint be dismissed against Dr. Plenge and that the **complaint be referred to the Full Board** with the recommendation that a **BOMEX Investigation be initiated into Dr. Gabroy's** management of patient's undergoing anticoagluation therapy.

"B" Complaint Reviews for Discussion and Board Action with Recommendation for Letter of Concern

L.L. M. vs. Earl Feng, M.D. (ORS-Gilbert), Inv. #9168 **CLC#1**

Following review and discussion of all pertinent and available information, it was moved by Dr. Guyette, seconded by Dr. Cho, and unanimously carried that this complaint be filed with an advisory **Letter of Concern to Dr. Earl Feng** for inappropriate treatment of a radial head/neck fracture.

J.B. (Patient: J.B.) vs. Joseph P. Aiello, M.D., (OPH-Phoenix) Inv. #9064 **CLC#2**

Following review and discussion of all pertinent and available information, it was moved by Dr. Guyette, seconded by Dr. Cho, and unanimously carried that this complaint be **dismissed against Dr. Joseph P. Aiello.**

Northwest Hospital vs. Hugh S. Miller, M.D., (OBG-MFM-Tucson) Inv. #9099 **CLC#3**

Following review and discussion of all pertinent and available information, it was moved by Dr. Krishna, seconded by Dr. Cho, and unanimously carried that this complaint be filed with an advisory **Letter of Concern to Dr. Hugh Miller** for omiting pertinent information from an application for hospital staff privileges.

J.O. (Patient: M.O.) vs. Charles E. McCorkle, Jr., M.D., Inv. #9271 **CLC#4**

The committee referred this **complaint to the Full Board to obtain legal advice** from the Board's legal counsel.

"C" Complaint Reviews for Board Action with Recommendation for Dismissal

J.W.G. vs. Joseph L. Longo, III, M.D. (ORS-Scottsdale), Inv. #8880 **C#1**

Following review and discussion of all pertinent and available information, it was moved by Dr. Krishna, seconded by Dr. Cho, and unanimously carried that this complaint be **dismissed against Dr. Joseph L. Longo.**

ARIZONA BOARD OF MEDICAL EXAMINERS

CERTIFIED MAIL/RETURN RECEIPT REQUESTED

May 15, 1995

Hugh Miller, M.D.
Post Office Box 30280
Tucson, Arizona 85712

Re: Complaint of M.C.I., Ph.D. against Hugh Miller, M.D. (Inv. #7282)

Dear Doctor Miller:

During the course of the Board's **April 3, 1995** meeting, the Board of Medical Examiners considered the above-referenced matter.

Following a complete and detailed review of all pertinent and available information, the Board concluded in Open Session that this matter should be filed with an advisory Letter of Concern. According to Arizona Revised Statutes §32-1401(14), a Letter of Concern is an advisory letter that notifies you that, while there is insufficient evidence to support disciplinary action, the Board believes that you should modify or eliminate certain practices and that continuation of these activities may result in disciplinary action. A Letter of Concern is not a disciplinary action.

Specifically, the Board was concerned with your failure to identify a second twin at 14 weeks gestation on ultrasound examination.

On behalf of the Board of Medical Examiners, please accept my appreciation for your assistance and cooperation in this matter.

Sincerely,

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

Mark R. Speicher

MARK R. SPEICHER
Executive Director

MRS/snm
CLC#2

cc: M.C.I., Ph.D.

effective as of _____. GERALD BECKER, M.D. acknowledges that any violation of this Order constitutes unprofessional conduct within A.R.S. §32-1401(24)(r), and may result in disciplinary action pursuant to A.R.S. §32-1451.

ORDER

Based upon the foregoing Stipulation, IT IS HEREBY ORDERED that GERALD BECKER, M.D. shall within ten (10) days of the date of this Order, voluntarily surrender his controlled substance registration certificate to the Drug Enforcement Administration and provide evidence of such surrender to the Board.

M.C.I. vs. Hugh Miller, M.D. (MFM-Tucson), Inv. #7282

CLC#2

(Dr. DeBenedetti did not participate in the discussion or voting of this matter)

Following a review of all pertinent records and discussion of this complaint, it was moved by Ms. Randolph, seconded by Holsey, and unanimously carried that this complaint be filed with an advisory ***Letter of Concern*** to Dr. Miller for failure to identify a second twin at 14 weeks gestation on ultrasound examination.

W.R.S. vs. Bruno Schabarum, M.D. (IM-Mesa), Inv. #7473 **CLC#3**

(Dr. Cho did not participate in the discussion or voting of this matter)

Following a review of all pertinent records and discussion of this complaint, it was moved by Dr. Weiss, seconded by Dr. Krishna, and unanimously carried that ***investigation into this complaint continue*** to allow staff to respond to concerns that there was a lack of physical examinations performed by Dr. Schabarum.

BOMEX Inquiry (05/25/94) (Pt: M.B.) vs. Jesus Lopezlira, M.D., (GP-Phoenix) **CLC#4**

A motion was offered by Dr. Weiss, seconded by Dr. Krishna, and unanimously carried that this ***BOMEX investigation continue,*** and that the Board adopt the following Order:

ORDER

The Arizona Board of Medical Examiners, pursuant to A.R.S. §32-1403(A)(1) and A.R.S. §32-1451(C), hereby orders that JESUS LOPEZLIRA, M.D. shall take and pass the Special Purpose Examination ("SPEX") in June 1995 with a score of 75 or greater.

The Board also voted that Dr. Lopezlira be requested to appear for an Informal Interview at the Board's October 1995 meeting.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

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

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Date: May 12, 1989

Re: License through Endorsement

Hugh Stephen Miller, M.D.
25 Berkeley Street
Somerville, MA 02143

Dear Doctor:

Congratulations! Your certificate to practice medicine in Arizona, License No. 18753 issued on MAY 12, 1989 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/ce
Enclosures: 6

SENDER: Complete items 1 and 2 when additional services are desired, and complete items 3 and 4.

Put your address in the "RETURN TO" Space on the reverse side. Failure to do this will prevent this card from being returned to you. The return receipt fee will provide you the name of the person delivered to and the date of delivery. For additional fees the following services are available. Consult postmaster for fees and check box(es) for additional service(s) requested.

1. ☐ Show to whom delivered, date, and addressee's address. *(Extra charge)*
2. ☐ Restricted Delivery *(Extra charge)*

3. Article Addressed to:	4. Article Number 502 114
	Type of Service: ☐ Registered ☐ Insured ☑ Certified ☐ COD ☐ Express Mail ☐ Return Receipt for Merchandise
	Always obtain signature of addressee or agent and DATE DELIVERED.
5. Signature – Address X	8. Addressee's Address *(ONLY if requested and fee paid)*
6. Signature – Agent X	
7. Date of Delivery	

PS Form **3811**, Mar. 1988 ★ U.S.G.P.O. 1988–212–865 **DOMESTIC RETURN RECEIPT**

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

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

DATE: April 27, 1989

Hugh Stephen Miller, 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, 2001 West Camelback Road, Suite 300, Phoenix, Arizona 85015. 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 not 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 indicate 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

MEDICAL AGENCY OF EMPLOYMENT

Dear Sir:

In applying for a license to practice medicine in the State of Arizona, the Medical Board requires this form to be completed by the medical agency wherein I am currently or have been employed for the past five years. This is your authority to release any information in your files, favorable or otherwise, DIRECT to the BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 West Camelback Road, #300, Phoenix, AZ 85015 Your early response is appreciated.

NAME: Hugh S. Miller, M.D. Hugh Miller, M.D.
(Signature)

ADDRESS: [redacted] Date: 4/12/89

The physician named above stipulates his/her whereabouts as including employment with your medical agency. We would appreciate your comments as to current or prior employment, together with any information you may possess, favorable or otherwise, regarding the doctor's employment. Your response will be held in strict confidence and we thank you for your cooperation. IF ADDITIONAL SPACE IS REQUIRED, PLEASE USE THE BACK OF THIS FORM.

NAME OF MEDICAL AGENCY: Upham's Corner Health Center

ADDRESS: 500 Columbia Rd. Dorchester MA 02125

Dates of employment with your agency: From March '88 (Month & Year) to June '89 (Month & Year)

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

see above

Were doctor's services performed in a satisfactory manner? yes

IF NO, please explain. —

Derogatory information, if any: none

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

Your name and title: Geoffrey Modest M.D. Medical Director
(Please Print or Type)

Signature: Geoffrey Modest M.D.

Date: 4/18/89

BOMEX

APR 21 1989

AGENCY SEAL OR STAMP
(Please indicate, if none)

There is no official stamp.
Geoffrey Modest M.D.

6 Modest MA

UPHAM'S CORNER HEALTH CENTER
UPHAM'S CORNER HEALTH COMMITTEE INC.
500 COLUMBIA ROAD
DORCHESTER, MASS. 02125

Board of Medical Examiners
State of Arizona
2001 west Camelback Rd #300
Phoenix AZ 85015

Executive Director
Douglas N. Cerf
Assoc. Executive Director
David O. Landrith
Manager, Licensure Dept.
Carol Emminger
Telephone
(602) 255-3751

THE ARIZONA BOARD OF MEDICAL EXAMINERS
2001 west camelback road, suite 300 • phoenix, arizona 85015

March 31, 1989

Hugh Stephen Miller, 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 A 029174 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:

Medcial Agency of Employment from Uphams Corner Health Center, Boston, MA. (form enclosed)

For your information Form I Medical College Certification has been returned for completion.

Continued:

NOTE: FINAL ACTION ON YOUR APPLICATION CANNOT BE TAKEN UNTIL ALL 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 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

(Mrs.) Carol Emminger
Manager, Licensure Department

CE: ct

Encs. 2

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

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

DATE: March 30, 1989

Re: Hugh Stephen Miller, M.D.

Janet S. Kerle, Registrar
Tufts University School of Medicine
145 Harrison Ave, Sackler 2,
Boston, MA 02111

Dear Sir:

Please find enclosed Form I Medical College Certification from Hugh S. Miller, M.D.

Would you kindly ~~affix~~ complete questions 1 through 6, grade card and Dean's letter are not acceptable.

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

Thank you for your cooperation.

Cordially,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

(Mrs.) Carol Emminger
Manager, Licensure Department

CE/ ct

Enc. 1

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Please be advised that the enclosed certificate is based entirely on examination of our open and closed complaint file. It is not based on a revi
the application for licensure, renewal of licensure or any reports that the Board is required to receive by statute (from Courts, Insurers, Hospita

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

March 6, 1989

To Whom It May Concern:

This is to certify that HUGH STEPHEN MILLER

a graduate of TUFTS UNIVERSITY SCHOOL OF MEDICINE in the year 1985

has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 57763 was issued to Dr. HUGH STEPHEN MILLER

on 6/3/87 THIS LICENSE IS CURRENT.

Expiration date: 07/18/89

Our files contain NO DEROGATORY information on this physician.

Andrew G. Bodnar, M.D., J.D.
Chairman

SEAL

BOMEX
MAR 10 1989

MEDICAL AGENCY OF EMPLOYMENT

Dear Sir:

In applying for a license to practice medicine in the State of Arizona, the Medical Board requires this form to be completed by the medical agency wherein I am currently or have been employed for the past five years. This is your authority to release any information in your files, favorable or otherwise, DIRECT to the BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 West Camelback Road, #300, Phoenix, AZ 85015 Your early response is appreciated.

NAME: HUGH STEPHEN MILLER, M.D. Hugh Miller, M.D.
(Signature)

ADDRESS: [redacted] Date: 2/25/89

The physician named above stipulates his/her whereabouts as including employment with your medical agency. We would appreciate your comments as to current or prior employment, together with any information you may possess, favorable or otherwise, regarding the doctor's employment. Your response will be held in strict confidence and we thank you for your cooperation. IF ADDITIONAL SPACE IS REQUIRED, PLEASE USE THE BACK OF THIS FORM.

NAME OF MEDICAL AGENCY: Tufts University School of Medicine Affiliated Hospitals OB/GYN Residency Program

ADDRESS: 90 Cushing Avenue, Boston, MA. 02111

Dates of employment with your agency: From 7/1/85 (Month & Year) to 6/30/89 (Month & Year)

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

Affiliated Hospitals in Program: - St. Margaret's Hospital for Women, 90 Cushing Ave., Boston, MA. 02125, New England Medical Center - 750 Washington St., Boston, MA. 02111, Cambridge Hospital, Cambridge, Ma. 02139.

Were doctor's services performed in a satisfactory manner? Yes

IF NO, please explain.

Derogatory information, if any: None

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

Your name and title: LINDA CALIGA PRESIDENT
(Please Print or Type)

Signature: Linda B. Caliga

Date: 2 March 1989

AGENCY SEAL OR STAMP
(Please indicate, if none)

BOMEX MAR 6 1989

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

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

Miller
Hugh

2/1/89

Hugh Miller, M.D.
[redacted]

Am Grad, 1985
National Board, 1986

ct

INFORMATION FORM FORWARDED 2-3 19 89.

RECIPROCITY - EXAM APPLICATION FORWARDED _____ 19 ___

APPLICATION & FORMS I II III IV V VI VII

Arizona Medical Board

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

April 02, 2015

Margaret F. Dean
Campbell Yost Clare Norell, PC
101 N. 1st Ave, Ste 2500
Phoenix, AZ 85003

Re: Hugh Stephen Miller MD
Case # MD-14-1066A

Dear Ms. Dean:

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

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

We appreciate your cooperation and patience during this process.

Sincerely,

Patricia E. McSorley
Executive Director

F" - Malpractice Reviews for Board Action with Recommendation for Dismissal From Medical Consultant

Following a review of the files and records listed below, including the malpractice complaint, physician's response, the report and recommendations of the Board's investigating member and staff medical investigator, it was moved by Dr. Krishna, seconded by Dr. Cho, and unanimously carried that the following malpractice complaints be **dismissed:**

D.E. vs Volker K. Sonntag, M.D. (NS - Phoenix), Inv. # 8719	M#1
R.D.H. vs. Lawrence Koep, M.D. (GS - Phoenix), Inv. # 9180	M#2
D.S.M. vs John P. Orchard, M.D. (CD-IM - Phoenix), Robert Rankel, M.D. (GS-VS - Peoria), R. Randall Grace, M.D. (CDS-TS - Phoenix), Ela Timbadia, M.D. (GS-VS - Glendale), Sydney Ozer, M.D. (AN - Phoenix), Inv. # 6332	M#3
C.J.G. vs. James H. Roe, M.D. (EM - Phoenix), Inv. # 4980	M#4
K.R. vs. Hugh Stephen Miller, M.D. (OBG - Tucson), Inv. # 3356	M#5
B.L.R. vs. Bashir A. Azher, M.D. (U - Bullhead City), Inv. # 9019	M#6
D.C. vs. Prido Polanco-Martinez, M.D. (GS-FP - Bisbee), Inv. # 8681	M#7
K.W. vs. Robert Miller, M.D. (EM - Phoenix), Inv. # 8691	M#8
C.H. vs. William Wright, M.D. (FP-OBS - Globe), Inv. # 8816	M#9
M.L. vs. Louis Rosati, M.D. (PTH - Phoenix) and Alice Police, M.D. (GS - Ketchum, Idaho), Inv. # 4989	M#10
T.G. vs. Holly Leeds, M.D. (GS - Berkeley, CA) and David R. Kies, M.D. (AN - Show Low), Inv. # 8817	M#11
J.S. vs. Gene A. Manzer, M.D. (OM - Phoenix) and Eric Baca, M.D. (OM-GP - Scottsdale), Inv. # 5092	M#12
M.W. vs. Joseph E. Fondriest, M.D. (DR - Granville, Ohio), Arnold Johnson, M.D. (DR - Vacacille, California), Robert Duran, M.D. (EM - Tucson, Arizona), Inv # 9078	M#13
E.V. vs. Charles Creasman, M.D. (ORS - Phoenix), Inv. # 8933	M#14
S.T. vs. Valerie Sorken-Wells, M.D. (OBG - Phoenix), Rodney Smith, M.D. (OBG - Phoenix), Inv. # 8743	M#15
B.L. vs. Boyd Burkhardt, M.D. (PS - Tucson), Armando J. Alfaro, Jr., M.D. (PS/HS - Tucson), Inv. # 6265	M#16
J.S. vs Egon V. Johnson, M.D. (ORS - Mesa), Inv. # 8735	M#17
B.B. vs. Thomas R. Carter, M.D. (ORS-SM - Phoenix), Inv. # 9075	M#18
M.B. vs. Neal Rockowitz, M.D. (ORS - Phoenix), Inv. # 9077	M#19
T.C. vs. Mark S. Ercius, M.D. (NS - Mesa), Inv # 8975	M#20
B.P. vs. Krantinath Raikhelkar, M.D. (GS - Riviera), Inv # 9002	M#21
R.C. vs. Gerald N. Yacobucci, M.D. (ORS - Glendale), Inv # 7990	M#22

AMB - Physician Renewal - Confirmation (Step 8 of 11) 7/18/2019

Hugh Stephen Miller

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

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

Valley Perinatal Services
2222 S Dobson Rd Suite 305
Mesa AZ, 85202

[redacted]

Contact: Alyssa Rodriquez
Contact Phone: 480-467-2175
Contact Email: contracting@medrevexperts.com
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.

AMB - Physician Renewal - Confirmation (Step 8 of 11) 7/18/2017

Hugh Stephen Miller

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

9440 E Ironwood Square Dr
Scottsdale AZ, 85258
Phone: (480) 756-6000
Fax: (480) 467-2165

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

Valley Perinatal Services
2222 S Dobson Rd Suite 305
Mesa AZ, 85202
[redacted]
Contact: Alyssa Rodriquez
Contact Phone: 480-467-2175
Contact Email: contracting@medrevexperts.com
You are required to enter a valid address, if you have one.

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

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

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

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

MD Training Unit
Complete

You may wish to print this Page for your records.

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

Arizona Medical Board

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

July 15, 2015

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

Dr. Hugh Stephen Miller
P.O. Box 30280
Tucson, AZ 85751-0280

[redacted]

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

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

1.) **Please provide government issued document that contains a photograph**. (ie: passport, driver's license)

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

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

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

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

R4-16-207. Time-frames for License Renewal; Expiration

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

Kendra Drake
Arizona Medical Board
Licensing Assistant
Kendra.Drake@azmd.gov

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

6/8/2015

Hugh Stephen Miller

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)
5301 E Grant Rd
Tucson AZ, 85712-2805
Phone: (520) 795-8188
Fax: (520) 325-0809

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

P.O. Box 30280

[redacted]

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

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

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

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

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

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

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

MD Training Unit

Complete

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Arizona Medical Board: License Renewal Questions

Hugh Miller 2013 License # 18753 Professional Conduct

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

Arizona Medical Board: License Renewal Questions

Hugh	Miller	2013	License # 18753	Mental Health

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

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

[redacted]

Arizona Medical Board: License Renewal Questions

Hugh Miller 2011 License # 18753 Professional Conduct

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

Arizona Medical Board: License Renewal Questions

Hugh	Miller	2011	License # 18753	Mental Health

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

Arizona Medical Board: License Renewal Questions

Hugh Miller 2009 License # 18753 Professional Conduct

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

Arizona Medical Board: License Renewal Questions

Hugh	Miller	2009	License # 18753	Mental Health

1. Since your last renewal, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?

2. Are you now being treated or since your last renewal have you been treated or for a drug or alcohol addiction or participated in a rehabilitation program? *If in a confidential program in another state see explanation below

3. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1)behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice? See below for definition of ability to practice medicine.

pd cc

ARIZONA MEDICAL BOARD
2007 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 18753 Hugh S. Miller, MD **Renewal Fee: $500 /$850** (if postmarked after **08/18/2007**)

CURRENT INFORMATION Please review and make corrections as necessary ™	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 5301 E Grant Rd Tucson AZ 85712-2805	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** RECEIVED JUN 13 2007 ARIZONA MEDICAL BOARD BUSINESS OPERATIONS
Phone #: (520) 795-8188 **Fax #:** (520) 325-0809	**Phone #:** **Fax #:**
E-Mail:	**E-Mail:**
MAILING ADDRESS PO Box 30280 Tucson AZ 85751-0280	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS** [redacted]
Phone #: [redacted] **Fax #:** [redacted]	**Phone #:** **Fax #:**
E-Mail: [redacted]	**E-Mail:**
Mobile #: [redacted]	**Mobile #:** (Optional)

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
	Verified Licensing			

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.

Hugh Miller 6/4/07

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

18753 Hugh S. Miller, MD

SEE REVERSE SIDE

ENTERED

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

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

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

INITIALS REQUIRED HM

1.	**Since your last renewal have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?**
2.	**Are you now or since your last renewal been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?**
3.	**Are you now being treated or since your last renewal have you been treated or evaluated for a drug or alcohol addiction or participated in a rehabilitation program?** *If in a confidential program in another state see explanation below.
4.	**Since your last renewal have you been criminally charged with or investigated by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility for inappropriate contact with a patient or patients?**
5.	**Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice?** **Ability to practice medicine is to be construed to include all of the following:** 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments; 2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and 3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids. "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to chronic and/or uncorrected orthopedic, visual, speech, or hearing impairments, epilepsy, multiple sclerosis, behavioral health illness, dementia, drug addiction and alcoholism.

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

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

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

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

18753 Hugh S. Miller, MD **INITIALS REQUIRED** HM

ARIZONA MEDICAL BOARD
2005 BIENNIAL MD LICENSE RENEWAL APPLICATION

Pd cc

AZ MD Lic#: 18753 Hugh S. Miller, MD Renewal Fee: $500 $850 (If postmarked after 08/18/2005)

CURRENT INFORMATION (Please review and make corrections as necessary)	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER 5301 E Grant Rd Tucson AZ 85712-2805	OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
Phone #: (520) 795-8188 Fax #: (520) 325-0809 E-Mail:	Phone #: Fax #: E-Mail:
MAILING ADDRESS PO Box 30280 Tucson AZ 85751-0280	MAILING ADDRESS
HOME ADDRESS [redacted]	HOME ADDRESS [redacted]
Phone #: [redacted] Fax #: E-Mail: [redacted]	Phone #: [redacted] Fax #: [redacted] E-Mail: Cell Phone #: [redacted] (Optional)

RECEIVED JUN 13 2005 By

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

	Certified?	Practicing?
OBG	Y	Y
MFM	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 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) 6/2/05 Date

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

Pd cc

ARIZONA MEDICAL BOARD
2003 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 18753 Hugh S. Miller, MD **Renewal Fee: $450** **$800** (If postmarked after 08/18/2003)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 5301 E Grant Rd Tucson AZ 85712-2805	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**
Phone #: (520) 795-8188 **Fax #:** (520) 325-0809 **E-Mail:**	**Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS PO Box 30280 Tucson AZ 85751-0280	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** **E-Mail:** [redacted]	**Phone #:** **Fax #:** **E-Mail:** **Cell Phone #:** (Optional)

RECEIVED JUN 2 2003 By

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

	Certified?	Practicing?
OBG	Y	Y
MFM	N	Y

Make corrections if necessary

	Certified?	Practicing?
MFM	Y	Y

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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 of Licensee (Signature stamp ~~will not be~~ accepted) — Date: 5/26/03

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