CC $550.00

RECEIVED
JUL 13 2017
ARIZONAMEDICALBOARD

ARIZONA MEDICAL BOARD
MD INITIAL AND ENDORSEMENT LICENSE APPLICATION

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

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

Personal Information

1. **First Name:** Elizabeth Lic # 54870
   Middle Name: Brett
   Last Name: Daily
   Other Names Used:
2. **Social Security Number:** [redacted]
3. **Date of Birth:** [redacted] **State of Birth:** [redacted]
   City of Birth: [redacted] **Country of Birth:** [redacted]

Social Security Number, Date of Birth and Place of Birth are Confidential Information - Not for Public Disclosure

Address Information

Practice Address: This is the practice/principal place of your business. The address and phone number provided will appear in the Medical Directory and on the Board's website. **Every physician must have an address available to the public.** If only one address is provided, even if it is your home address, it will be available to the public upon request. If you want your home address to be listed as your practice address on the Board's website, include the address in the practice address field.

4. **Practice/Training Name:** Wesley Community Center
   Address: 1300 S. 10th Street **City:** Phoenix **State:** AZ **Zip:** 85034
   Phone: 602 257 4323 **Fax:** 602 252 5768 ***Practice address not required for licensure**

Home Address: You are **required** to provide a home address, telephone number and email address. Your home address and telephone number will not be released to the public *unless* you fail to provide an office address. Your email address will not be released to the public, but the Board may occasionally send relevant news and information to you via email.

5. **Home Address:** [redacted] **City:** [redacted] **State:** [redacted] **Zip:** [redacted]
   Phone: [redacted] **Mobile:** [redacted]
   Primary Email Address: [redacted]

ENTERED

Mailing Address: If no address is provided, all Board correspondence will be sent to your practice address.
Please note - Your fingerprint packet will be sent to your mailing address.

6. **Mailing Address:** [redacted] **City:** [redacted] **State:** [redacted] **Zip:** [redacted]

☐ Same as Practice Address ☑ Same as Home Address

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

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

RECEIVED
JUL 18 2017
ARIZONA MEDICAL BOARD

Name		Phone#		E-mail	
Name		Phone#		E-mail	

☐ **Check this box if you are using Federation Credentials Verification Service (FCVS)**

Please Note: The Arizona Medical Board accepts FCVS documents that are received by the Board directly from the Federation of State Medical Boards (FSMB) as verification. Contact the Federation at http://www.fsmb.org if you need more information regarding this service.

☐ **Once granted licensure in Arizona, I would like to review cases for the Board. I have 5 years + experience (excludes PGT).**

If you are interested please go to www.azmd.gov for more details. Please list your Specialty, Sub Specialty, or type of procedures that you are qualified to review.

Specialty/Sub Specialty/procedures:

7. Other State Medical License(s)

Please list all states, provinces or U.S. territories in which you have applied for or have been granted a license or registration to practice medicine, including license number, date issued and current status of the license. If more than 10, attach a separate listing. If a license is pending or was not issued, so state. Please do not list registrations or post graduate training license(s). If none, please indicate "Not Applicable".

State Board:	License No.:	Date Issued:	License Status:
N/A			

First Name: Elizabeth **Last Name:** Daily

8. Medical Education

Medical School Name: The University of Kansas School of Medicine

Medical School Location: Kansas City, Kansas **Graduation Date:** 12/2013

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

ECFMG No.: **Certificate Date:**

☐ *I am able to read, write, speak, understand and be understood in the English language.*

9. Post Graduate Training

List chronologically, all internship, residency and fellowship training in the U.S. or Canada (completed or not), or assistant professorship (or higher, if needed to meet requirements) at any program attended, showing institution, address, type of program, specialty and dates. Attach a separate listing, if needed.

a. **Institution:** Banner University Medical Center **City:** Phoenix **State:** AZ

Dates of Attendance: **From:** 7/14 **To:** 7/17 **Type of Program:** Residency

Specialty: Family Medicine

b. **Institution:** **City:** **State:**

Dates of Attendance: **From:** **To:** **Type of Program:**

Specialty:

c. **Institution:** **City:** **State:**

Dates of Attendance: **From:** **To:** **Type of Program:**

Specialty:

d. **Institution:** **City:** **State:**

Dates of Attendance: **From:** **To:** **Type of Program:**

Specialty:

e. **Institution:** **City:** **State:**

Dates of Attendance: **From:** **To:** **Type of Program:**

Specialty:

First Name: Elizabeth **Last Name:** Daily

10. Examinations

Please indicate all exams taken.

☑ United States Medical Licensing Exam (USMLE)	☐ National Board of Medical Boards Licensing Examination (NBME)
☐ State Written Exam ***(The Commonwealth of Puerto Rico Exam is not accepted)***	☐ Federation of State Medical Boards Licensing Examination (FLEX)
☐ Licentiate of the Medical Council of Canada (LMCC)	☐ Special Purpose Examination (SPEX)

11. Area of Interest/ABMS Certification

Indicate your area of interest/specialty (present or future, can be updated if needed) and whether you are certified by the American Board of Medical Specialties (ABMS). This must be completed.

Area of Interest	Practicing?	ABMS Certified?	Expiration Date (Or indicate if lifetime certificate)
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

12. Citizenship Attestation

Proof of Citizenship: Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States. Pursuant to A.R.S. § 41-1080 and A.A.C. R4-16-201(C)(1) require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona.

☑ **I am a U.S. Citizen or U.S. National.**	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (Also review the application checklist).
☐ **I am NOT a U.S. Citizen or U.S. National.**	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (Also review the application checklist).

13. Training Unit Attestation

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

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

Revised 10/20/15

Full Name (print): Elizabeth Brett Daily **Signature:** [signature] **Date:** 7/5/2017

14. Questionnaire

1. Have you had an application for medical licensure denied or rejected by another state or province licensing board?	☐ Yes	☑ No
2. Have you had any disciplinary or rehabilitative action taken against you by another licensing board, including other health professions?	☐ Yes	☑ No
3. Have you had any disciplinary actions, restrictions or limitations taken against you while participating in any type of training program or by any health care provider?	☐ Yes	☑ No
4. Have you been found in violation of a statute, rule, or regulation of any domestic or foreign governmental agency?	☐ Yes	☑ No
5. Are you currently under investigation by any medical board or peer review body?	☐ Yes	☑ No
6. Have you ever had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation during an investigation, or entered into a consent agreement or stipulation?	☐ Yes	☑ No
7. Have you had hospital privileges revoked, denied, suspended, or restricted?	☐ Yes	☑ No
8. Have you been named as a defendant in a malpractice matter currently pending or that resulted in a settlement or judgment against you? If so, provide a copy of the complaint and either the agreed terms of settlement or the judgment and a statement specifying the nature of the occurrence resulting in the medical malpractice action. **Do not disclose cases closed without payment made on your behalf.**	☐ Yes	☑ No
9. Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by an agency of the federal or state government?	☐ Yes	☑ No
10. Have you had the authority to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency as a result of disciplinary or other adverse action?	☐ Yes	☑ No
11. Have you been found guilty or entered into a plea of no contest to a felony, or a misdemeanor involving moral turpitude in any state?	☐ Yes	☑ No

15. Confidential Questions

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

A.) A detailed description of the use, disorder, or condition; and
B.) An explanation of whether the use, disorder, or condition is reduced or ameliorated because you receive ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating.
C.) A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.

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

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

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

First Name: Elizabeth **Last Name:** Daily

16. Hospital Affiliations/Medical Employment Verifications

Please answer all questions and list all hospital affiliations and medical employment within the past five (5) years, including moonlighting and courtesy staff affiliations. *Do not include postgraduate training or self-employment.* List all physician placement groups related to hospital employment, emergency medical groups, radiology groups, etc. This form must be completed.

1. I have been self-employed for the past 5 years. (If yes do not list your self-employment below) ☐ Yes ☑ No
2. My only medical employment for the past 5 years has been postgraduate training. (If yes do not list your postgraduate training below.) ☑ Yes ☐ No
3. I have had no medical employment for the past 5 years. ☐ Yes ☑ No
4. I have not held hospital affiliations within the past 5 years or I am currently in postgraduate training. (If yes do not list your postgraduate training below.) ☑ Yes ☐ No

a. **Name:** From: To:

Address: City: State: Zip:

Position Held: ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

b. **Name:** From: To:

Address: City: State: Zip:

Position Held: ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

c. **Name:** From: To:

Address: City: State: Zip:

Position Held: ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

d. **Name:** From: To:

Address: City: State: Zip:

Position Held: ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

e. **Name:** From: To:

Address: City: State: Zip:

Position Held: ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

First Name: Elizabeth Daily **Last Name:** Daily

17. Arizona Medical Board Application Attestation

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

Signature of Applicant: Elizabeth Daily Date: 7/5/2017

Notarization

Subscribed and sworn in front of me by ELIZABETH DAILY, personally appearing on this date 7-12-17.

Notary Public's Signature

(Personalized Seal)

MARK V. MALATESTA
Notary Public - State of Arizona
MARICOPA COUNTY
My Commission Expires
May 21, 2020

First Name: Elizabeth Last Name: Daily

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public is Required

Applicant Full Legal Name: DAILY (Last) ELIZABETH (First) BRETT (Middle)

Notary - Please complete the section below and attach a photocopy of the Birth Certificate or Passport.

State of ARIZONA County of MARICOPA

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this

(Day) 12TH, of (Month) JULY, (Year) 2017.

Notary Public Signature: Mark V Malatesta

Commission Expiration Date* (Month) MAY /(Day) 21 /(Year) 2020

***The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Applicant's Signature: Elizabeth Daily

Notary Stamp Here

MARK V. MALATESTA
Notary Public - State of Arizona
MARICOPA COUNTY
My Commission Expires
May 21, 2020

Please complete and mail or email the notarized Certificate of Identification form and a photocopy of the Birth Certificate or Passport presented to the Notary to:

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

Licensingreport@azmd.gov

The University of Arizona

College of Medicine – Phoenix

certifies that

Elizabeth Brett Daily, MD

has fulfilled the academic and clinical requirements of the

Residency Program in Family Medicine

from 6/23/2014 to 6/30/2017

Kenneth S. Ramos, MD, PhD
Dean, College of Medicine – Phoenix

Alan I. Leshner, MD
Associate Dean for Graduate Medical Education

SIGILLVM VNIVERSITATIS ARIZONENSIS 1885

Steven K. Barrus, MD
Program Director

Jenny Wolfrey, MD
Department Chair

10. Examination

[illegible]

☑ United States Medical Licensing Exam (USMLE)	☐ National Board of Medical Boards Licensing Examination (NBME)
☐ State Written Exam *(The Commonwealth of Puerto Rico Exam is not accepted)*	☐ Federation of State Medical Boards Licensing Examination (FLEX)
☐ Licentiate of the Medical Council of Canada (LMCC)	☐ Special Purpose Examination (SPEX)

11. Area of Interest/ABMS Certification

[illegible]

Area of Interest	Practicing?	ABMS Certified?	Expiration Date (Or Indicate if lifetime certificate)
Family Medicine	☑ Yes ☐ No	☐ Yes ☑ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

12. Citizenship Attestation

[illegible] Arizona.

☑ I am a U.S. Citizen or U.S. National.	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (Also review the application checklist).
☐ I am NOT a U.S. Citizen or U.S. National.	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (Also review the application checklist).

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

Revised 10/20/15

Full Name (print): Elizabeth Brett Daily

Signature: [signature]

Date: 7/5/2017

From: [redacted]
To: Marisela Newcomb
Subject: Missing paperwork
Date: Wednesday, July 26, 2017 10:48:17 AM
Attachments: [redacted]

Hi Marisela,

Will this work for you?

Also, I will request the diploma from my medical school today.

Please let me know if there is anything else I need to do! Thank you so much for your help.

Arizona Medical Board

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

July 17, 2017

Elizabeth Daily, MD
[redacted]

Email Address: [redacted]

Dear Dr. Daily:

Please accept this letter as receipt of your application for licensure to practice medicine in the State of Arizona. I reviewed your application submission. To complete the processing of your application, the following documentation is still required:

1. **Submit a full set of fingerprints to the board for the purpose of obtaining a state and federal criminal records check.**
   The Board mailed a Fingerprint Packet to your current mailing address. You should receive the packet in approximately 5 working days. **Please follow the directions exactly, to avoid any delay in processing your application.**

2. **Medical College Certification for National Graduates**
   One of the following must be submitted directly from your medical school to the Board:
   a. An official copy of your medical school transcripts, OR
   b. A copy of your diploma, or
   c. A letter with an official letterhead that confirms successful completion

3. **2. Complete application page 4, item #11 – Area of Interest (attached)**

4. **12 months ACGME Approved Postgraduate Training Verification**
   U.S. or Canadian Graduates: 12 months of ACGME and/or RCPSC approved post graduate training

*Note: Some information may be provided in an FCVS Packet, if you use their service. Upon further review, additional information may be requested.

Although not needed for basic license requirements, if you would like additional post graduate training years to be listed on the Board's website, verification must be submitted directly from the source to the Board.

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

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

Should you wish to appeal any item in this deficiency letter, you must submit your request in

writing to the Board within 30 days from the date of this notice.

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

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

Sincerely,

Marisela Newcomb
Licensing Coordinator
Marisela.Newcomb@azmd.gov
Arizona Medical Board

10. Examinations

Please indicate all exams taken.

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☐ State Written Exam ***(The Commonwealth of Puerto Rico Exam is not accepted)***	☐ Federation of State Medical Boards Licensing Examination (FLEX)
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Area of Interest	Practicing?	ABMS Certified?	Expiration Date (Or indicate if lifetime certificate)
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

12. Citizenship Attestation

Proof of Citizenship: Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States. Pursuant to A.R.S. § 41-1080 and A.A.C. R4-16-201(C)(1), require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona.

☑ **I am a U.S. Citizen or U.S. National.**	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (Also review the application checklist).
☐ **I am NOT a U.S. Citizen or U.S. National.**	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (Also review the application checklist).

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Revised 10/20/15

Full Name (print): Elizabeth Brett Daily **Signature:** [signature]

Date: 7/5/2017

The University of Kansas

By the authority of the Board of Regents of the State of Kansas
and upon the recommendation of the faculty of the

SCHOOL OF MEDICINE

confers upon

Elizabeth Brett Daily

the degree of

DOCTOR OF MEDICINE

with all its rights, privileges, and responsibilities.
Given under the seal of the University of Kansas this
thirty-first day of December, two thousand and thirteen.

Bernadette Gray-Little
Chancellor

Steve A. Logan Jr.
Chair, Kansas Board of Regents

I certify this to be a true and accurate copy of the original diploma awarded to Elizabeth Brett Daily for the Doctor of Medicine degree by The University of Kansas on December 31, 2013.

Marla J. Herron
Campus Registrar
August 3, 2017

KU THE UNIVERSITY OF KANSAS
Medical Center

Office of the Registrar
Mail Stop 4029, 3901 Rainbow Blvd.
Kansas City, KS 66160

Address Service Requested

neopost
08/04/2017
US POSTAGE

FIRST-CLASS MAIL
PRSRT
$00.45[3]

ZIP 66160
041L11236817

Arizona Medical Board
Re: Elizabeth Daily, MD, License
9545 E Doubletree Ranch Road
Scottsdale, Arizona
85258

42 FAGOJMP 85258

ARIZONA MEDICAL BOARD
POSTGRADUATE TRAINING VERIFICATION FORM

AUTHORIZATION: The Arizona Medical Board requires all applicants for licensure to obtain verification of all postgraduate training programs attended. This form must be completed by the **Program Director**. This is authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board. Authorization may be sent via mail to 9545 E Doubletree Ranch Road, Scottsdale, AZ 85258, fax with cover letter: 480-551-2704 or by email to licensingreport@azmd.gov.

First Name: ELIZABETH **Middle Name:** BRETT **Last Name:** DAILY

Signature: [signature] **Date:** 7/20/2017

Applicant: Do not fill in below this line.

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

PG Year: 1 **Department/Specialty:** FAMILY MEDICINE

- [x] Internship
- [ ] Residency
- [ ] Fellowship

From: 06/23/14 To: 06/30/15 (mm/dd/yy)

Successfully Completed? [x] Yes [ ] No [ ] In Progress

PG Year: 2 **Department/Specialty:** FAMILY MEDICINE

- [ ] Internship
- [x] Residency
- [ ] Fellowship

From: 07/01/15 To: 06/30/16 (mm/dd/yy)

Successfully Completed? [x] Yes [ ] No [ ] In Progress

PG Year: 3 **Department/Specialty:** FAMILY MEDICINE

- [ ] Internship
- [x] Residency
- [ ] Fellowship

From: 07/01/16 To: 06/30/17 (mm/dd/yy)

Successfully Completed? [x] Yes [ ] No [ ] In Progress

1. This program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Examination Education (ACGME), or the Royal College of Physicians and Surgeons of Canada: [x] Yes [ ] No
2. Did this individual ever take a leave of absence or break from training or request a transfer? [ ] Yes [x] No (If yes, please attach an explanation)
3. Was this individual disciplined and/or placed under investigation or probation? [ ] Yes [x] No (If yes, please attach an explanation)

Institution Name: UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE PHOENIX FAMILY MEDICINE RESIDENCY **Name:** STEVEN R. BROWN, M.D.

Address: 1300 N. 12TH STREET SUITE 1005 **Title:** RESIDENCY PROGRAM DIRECTOR

City: PHOENIX **State:** AZ **Zip:** 85006 **Phone:** 602.839.4567 **Fax:** 602.839.2067

Signature: [signature] **Date:** 7/19/17 (mm/dd/yy)

From:	Guevara, Catina N
To:	Marisela Newcomb
Subject:	AZ Med Board Verification ICO Elizabeth Brett Daily, MD
Date:	Friday, July 21, 2017 12:28:59 PM
Attachments:	AZ Med Board Verification ICO Elizabeth Brett Daily, MD.pdf

Good Afternoon Marisela,

Please see attached documentation verifying Dr. Daily's Postgraduate training.

Respectfully,

Catina Guevara
Senior Administrative Assistant – Family Medicine Clinic
Fellowship Program Coordinator – Primary Care Sports Medicine Fellowship

Banner University Medical Center Phoenix
1300 N. 12th St, Suite 605
Phoenix, AZ 85006
catina.guevara@bannerhealth.com
602.839.2601 office
602.839.2067 fax

Banner University Medical Center
Phoenix Campus

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Recipient: ARIZONA MEDICAL BOARD

Date: 07/05/2017

Examinee: Daily, Elizabeth Brett

Examinee ID: 52545928

Alt Name(s):

Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
3/30/2012	Pass	218	(188)	
9/21/2011	Fail	185	(188)	
6/11/2011	Fail	185	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
5/16/2013	Pass	236	(196)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
8/29/2013	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
6/1/2017	Pass	206	(196)	

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

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Examinee: Daily, Elizabeth Brett

Examinee ID: 52545928

Date of Birth: [redacted]

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

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

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"

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

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

Gmail by Google

Vicki Devore <vicki.devore@azmd.gov>

Fwd: Comments from Arizona Medical Board Website

1 message

Licensing Report - MEDICAL BOARD <licensingreport@azmd.gov> Fri, Jan 25, 2019 at 11:35 AM
To: Vicki Devore <vicki.devore@azmd.gov>

Arizona Medical Board
Arizona Regulatory Board of Physician Assistants
licensingreport@azmd.gov

---------- Forwarded message ---------
From: **Elizabeth Daily** <questions-noreply@azmd.gov>
Date: Fri, Jan 25, 2019 at 11:16 AM
Subject: Comments from Arizona Medical Board Website
To: <licensingreport@azmd.gov>

Licensing Questions / Comments Contact Us Message
From: Elizabeth Daily
Phon [redacted]
Email:

Message: Hello,
I'm a physician and I just applied for my license in Arizona to be renewed. However, it stated that I was not board certified and I am! I don't know how to update this information. Can you please help me? I was board certified by the ABFM (American Board of Family Medicine) in November, 2017. The expiration date will be November, 2027. Thank you!

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

1/25/2019

Dr. Elizabeth Brett Daily

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	Family Medicine	No	Yes		
Specialty 2					
Specialty 3					
Specialty 4					

Practice Address

Planned Parenthood
4401 West 109th St. Unit 100
Leawood KS, 66211
Phone: (913) 345-1400
Fax:

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

Home Address

[redacted]

Mailing Address

[redacted]

Contact: None
Contact Phone:
Contact Email:
You are required to enter a valid address, if you have one.

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

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

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

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

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

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

MD Training Unit

Complete

You may wish to print this Page for your records.

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