

CC \$550.00

RECEIVED

JUL 19 2017

ARIZONA MEDICAL BOARD

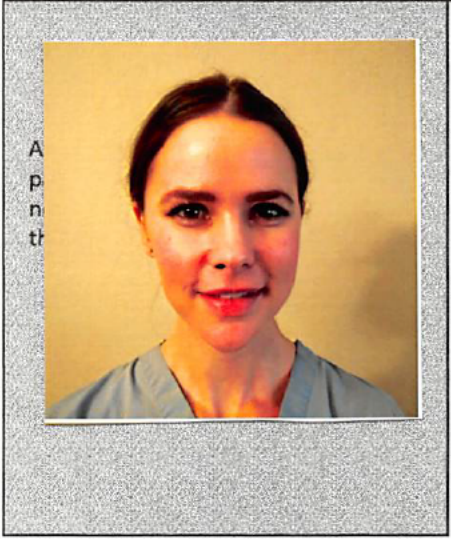


# ARIZONA MEDICAL BOARD MD INITIAL AND ENDORSEMENT LICENSE APPLICATION

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

3. Date of Birth: \_\_\_\_\_ State of Birth: \_\_\_\_\_

City of Birth: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

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. 10<sup>th</sup> 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: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Primary Email Address: \_\_\_\_\_

**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: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Same as Practice Address  Same as Home Address

In addition to your primary e-mail address provided on page one of this application, please indicate if you would like to designate/authorize an individual 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

Name  Phone#  E-mail

Name  Phone#  E-mail

ARIZONA MEDICAL BOARD

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](http://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:  Last Name:

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:	
<input checked="" type="checkbox"/> United States Medical Licensing Exam (USMLE)	<input type="checkbox"/> National Board of Medical Boards Licensing Examination (NBME)
<input type="checkbox"/> State Written Exam ( <i>The Commonwealth of Puerto Rico Exam is not accepted</i> )	<input type="checkbox"/> Federation of State Medical Boards Licensing Examination (FLEX)
<input type="checkbox"/> Licentiate of the Medical Council of Canada (LMCC)	<input type="checkbox"/> 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)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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. § 31-1080 and A.A.C. R4-16-2016(D), 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.	
<input checked="" type="checkbox"/> 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).
<input type="checkbox"/> 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.	
<b><i>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.</i></b>	
Revised 10/20/15	

Full Name (print):  Signature:

Date:

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:  Last Name:

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:  Last Name:

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

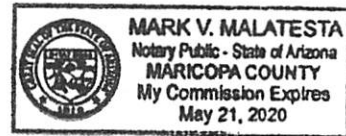
Date: 7/5/2017

Notarization

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

Mark V. Malatesta  
Notary Public's Signature

(Personalized Seal)



First Name: Elizabeth

Last Name: Daily

# CERTIFICATION OF IDENTIFICATION

Certification by Notary Public is Required

Applicant Full Legal Name: DAILY ELIZABETH BRETT  
Last First 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) 12<sup>th</sup>, of (Month) July, (Year) 2017.

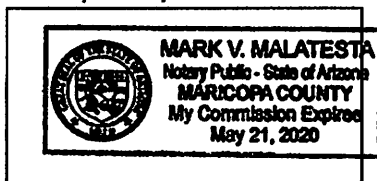
Notary Public Signature: Mark Malatesta

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



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

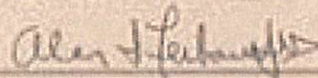
College of Medicine - Phoenix  
certifies that

## Elizabeth Brett Daily, MD

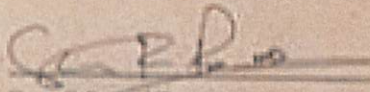
has fulfilled the academic and clinical requirements of the  
Residency Program in Family Medicine

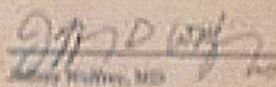
from 6/23/2011 to 6/30/2017

  
\_\_\_\_\_  
Kenneth S. Ramos, MD, PhD  
Dean, College of Medicine - Phoenix

  
\_\_\_\_\_  
Alan L. Lebowitz, MD  
Associate Dean for Graduate Medical Education



  
\_\_\_\_\_  
Steven K. Jenkins, MD  
Program Director

  
\_\_\_\_\_  
Jeffrey Wallace, MD  
Department Chair

10.

## Examination

<input checked="" type="checkbox"/> United States Medical Licensing Exam (USMLE)	<input type="checkbox"/> National Board of Medical Boards Licensing Examination (NBME)
<input type="checkbox"/> State Written Exam (The Commonwealth of Puerto Rico Exam is not accepted)	<input type="checkbox"/> Federation of State Medical Boards Licensing Examination (FLEX)
<input type="checkbox"/> Licentiate of the Medical Council of Canada (LMCC)	<input type="checkbox"/> Special Purpose Examination (SPEX)

11.

## Area of Interest/ABMS Certification

Area of Interest	Practicing?	ABMS Certified?	Expiration Date (Or indicate if lifetime certificate)
Family Medicine	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

12.

## Citizenship Attestation

<input checked="" type="checkbox"/> 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).
<input type="checkbox"/> 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 10/2015

Full Name (print):

Elizabeth Brett Daily

Signature:

Elizabeth Daily

Date:

7/5/2017

Page 4 of 10

**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](http://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](mailto:Marisela.Newcomb@azmd.gov)  
Arizona Medical Board

10. Examinations	
Please indicate all exams taken.	
<input checked="" type="checkbox"/> United States Medical Licensing Exam (USMLE)	<input type="checkbox"/> National Board of Medical Boards Licensing Examination (NBME)
<input type="checkbox"/> State Written Exam ( <i>The Commonwealth of Puerto Rico Exam is not accepted</i> )	<input type="checkbox"/> Federation of State Medical Boards Licensing Examination (FLEX)
<input type="checkbox"/> Licentiate of the Medical Council of Canada (LMCC)	<input type="checkbox"/> 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)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

12. Citizenship Attestation	
<p><b>Proof of Citizenship:</b> 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. § 5-41-1080 and A.A.C. R4-16-201(C)(4) 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.</p>	
<input checked="" type="checkbox"/> 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).
<input type="checkbox"/> 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	
<p>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.</p> <p><b>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.</b></p> <p>Revised 10/20/15</p>	

Full Name (print): Elizabeth Brett Daily      Signature: Elizabeth Brett Daily

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

*Paul F. Logan, Jr.*

Chair, Kansas Board of Regents

Marla J. Herron  
Campus Registrar  
August 3, 2017

*Marla J. Herron*

RECEIVED  
AUG 08 2017  
ARIZONA  
MEDICAL BOARD

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.

**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<sup>®</sup>  
08/04/2017  
**US POSTAGE**

FIRST-CLASS MAIL  
PRSRT  
**\$00.45<sup>3</sup>**



ZIP 66160  
041L11236817

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

42

FAGQJNF

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](mailto:licensingreport@azmd.gov).

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

Signature: [Handwritten 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  
 Internship  
 Residency From: 06/23/14 To: 06/30/15 (mm/dd/yy)  
 Fellowship Successfully Completed?  Yes  No  In Progress

PG Year: 2 Department/Specialty: FAMILY MEDICINE  
 Internship  
 Residency From: 07/01/15 To: 06/30/16 (mm/dd/yy)  
 Fellowship Successfully Completed?  Yes  No  In Progress

PG Year: 3 Department/Specialty: FAMILY MEDICINE  
 Internship  
 Residency From: 07/01/16 To: 06/30/17 (mm/dd/yy)  
 Fellowship Successfully Completed?  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:  Yes  No
2. Did this individual ever take a leave of absence or break from training or request a transfer?  Yes  No (If yes, please attach an explanation)
3. Was this individual disciplined and/or placed under investigation or probation?  Yes  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 405 Title: RESIDENCY PROGRAM DIRECTOR  
 City: PHOENIX State: AZ Zip: 85006 Phone: 602.839.4567 Fax: 602.839.2007  
 Signature: [Handwritten 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. 12<sup>th</sup> St, Suite 605

Phoenix, AZ 85006

[catina.guevara@bannerhealth.com](mailto:catina.guevara@bannerhealth.com)

602.839.2601 office

602.839.2067 fax





# 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 Wisner Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Recipient:

Date:

07/05/2017

ARIZONA MEDICAL BOARD

Examinee: Daily, Elizabeth Brett

Examinee ID: 52545928

Alt Name(s):

Date of Birth:



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 Wisser 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.*



Vicki Devore &lt;vicki.devore@azmd.gov&gt;

---

**Fwd: Comments from Arizona Medical Board Website**

1 message

---

**Licensing Report - MEDICAL BOARD** <licensingreport@azmd.gov>  
To: Vicki Devore <vicki.devore@azmd.gov>

Fri, Jan 25, 2019 at 11:35 AM

Arizona Medical Board  
Arizona Regulatory Board of Physician Assistants  
[licensingreport@azmd.gov](mailto:licensingreport@azmd.gov)

----- Forwarded message -----

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

Licensing Questions / Comments Contact Us Message

From: Elizabeth Daily

Phon

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 "YES"**, 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

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 .

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.

2) This question has been deleted.



### *Citizenship Status*

*I am a U.S. Citizen or U.S. National*

### *Specialties*

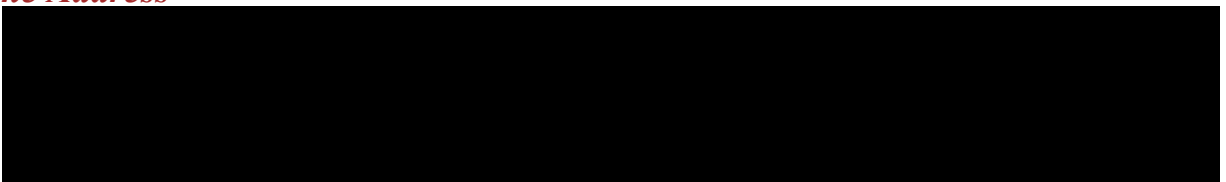
	<u>Specialty</u>	<u>Certified?</u>	<u>Practicing?</u>	<u>Date Certified</u>	<u>Expiration Date</u>
Primary Specialty	Family Medicine	No	Yes		
Specialty 2					
Specialty 3					
Specialty 4					

### *Practice Address*

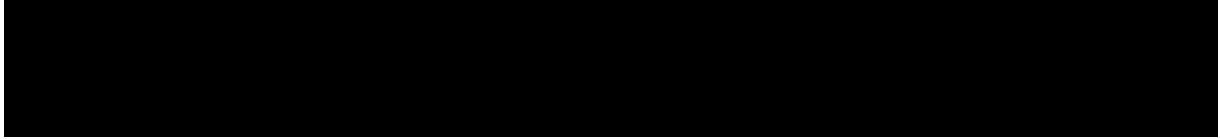
Planned Parenthood 4401 West 109th St. Unit 100 Leawood KS, 66211 Phone: (913) 345-1400 Fax:
--

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

### *Home Address*





***Mailing Address***

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

<b>Yes</b>	<b>No</b>
------------	-----------

***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.