PD CC

$500

APPLICATION

MAR 04 2008

Official Use Only: Inquiry # 48585 Date Application Received _____

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

1. Present Name Wyatt (Last) Sabrina (First) Noel (Middle) N/A (Maiden)

   (a) Other names used: N/A

2. Office/Training Address: P.O. Box 100294 (No.) (Street) Gainesville (City) FL (State) 32610 (Zip/Post Code)

3. All States or provinces in which you **have or had** a license or registration. If more than five, attach separate listing. If license is pending or was not issued, so state. If none, please indicate by stating "Not Applicable."

   (a) N/A
   (State Board) (License No.)(Status of License, i.e., expired, active, etc.)

   (b) _____
   (State Board) (License No.)(Status of License, i.e., expired, active, etc.)

   (c) _____
   (State Board) (License No.)(Status of License, i.e., expired, active, etc.)

   (d) _____
   (State Board) (License No.)(Status of License, i.e., expired, active, etc.)

   (e) _____
   (State Board) (License No.)(Status of License, i.e., expired, active, etc.)

4. Medical School Name: University of Alabama School of Medicine

   Medical School Location: Birmingham Alabama Date of Graduation: 06/05/2004 (Month/Day/Year)

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

   ECFMG # N/A Certificate Date: _____ (Month/Day/Year)

5. List chronologically, all Internship, Residency and Fellowship training in U.S. or Canada **(COMPLETED OR NOT)**, or Assistant Professorship (or higher) at any programs attended, showing institution, address, type of program and dates. Attach separate listing if needed.

INSTITUTION NAME	CITY/STATE	TYPE OF PROGRAM/PGY YEAR	DATES OF ATTENDANCE
University of Florida	Gainesville, Florida	OB/GYN Residency	06/04 – present

ENTERED

6. License Exam: Please indicate all exams taken, the date(s) taken (month/day/year) and what state, if applicable:

   a. United States Medical Licensing Exam (USMLE)
   06/2001 (Step I (Date)) 07/2003 (Step II (Date)) 08/2005 (Step III (Date)) N/A (State)
   b. State Written Examination Date N/A State _____
   (The Commonwealth of Puerto Rico written examination is not accepted)
   c. National Board of Medical Examiners Examination (NBME) Certification Date N/A
   d. Federation of State Medical Boards Licensing Examination (FLEX) Date(s) N/A (Comp I (Date)) _____ (Comp II (Date))
   e. Licentiate of the Medical Council of Canada (LMCC) Date N/A
   f. Special Purpose Examination (SPEX) Date N/A State _____

7. Indicate your area of practice: Obstetrics and Gynecology

8. List all certifications and re-certifications by a board or sub-board recognized by the American Board of Medical Specialties only.

Specialty Board	Certification #	Dates of Certification/Recertification	Expiration Date
N/A			

9. Account for, in **chronological order**, all activities since graduation from medical school to present. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. Attach a separate sheet if necessary. DO NOT ATTACH A CURRICULUM VITA (CV).**

ACTIVITIES	LOCATION	FROM/TO (MONTH/YEAR)
(e.g.) Preparation for USMLE Examination	City/State	06/00 to 01/00
University of Florida Residency	Gainesville, Florida	06/04 to present

10. Have you ever had any application for any professional license refused or denied by any licensing authority?	YES ☐	NO ☒
11. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐	NO ☒
12. Have you ever been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled?	YES ☐	NO ☒
13. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently?	YES ☐	NO ☒
14. Have you ever voluntarily surrendered any healthcare license?	YES ☐	NO ☒
15. Have you ever had any healthcare license revoked?	YES ☐	NO ☒
16. Have you ever been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☒
17. Have your privileges ever 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 ☒
18. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.	YES ☐	NO ☒
19. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?.	YES ☐	NO ☒
20. Have you ever 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 ☒
21. Have you ever 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 ☒
22. Have you ever 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 ☒
23. In the last ten (10) years has a judgment or settlement been entered against you as a defendant in a medical malpractice suit? ***Please do not report pending malpractice suits or settlements paid not related to a civil action.**	YES ☐	NO ☒
24. Have you ever been court martialed or discharged other than honorably from the armed service?	YES ☐	NO ☒
25. Have you ever been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐	NO ☒
26. Have you ever 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 10 through 26 is "YES",*** **the applicant must 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 result of any hearings, and the disposition of such charge(s). IN ADDITION, the applicant must submit photocopies of any complaints, hearings, settlements or judgments together with copies of patient's hospital and/or office records to the AMB.**

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.

Applicant Name Sabrina N. Wyatt, M.D. (3)

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

1.	Within the last five years, 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 have you in the last 5 years been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?
3.	Are you now being treated or have you in the last 5 years 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.	Have you ever 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? **See below for definition of ability to practice medicine.**

In the event you answer YES to any of the above questions, **you must file with the application a detailed written narrative statement concerning the above matter(s), including the name and address of all training programs or 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. This must be sent directly to the AMB.**

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 APPLICATION 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, INCLUDING REVOCATION OR DENIAL OF A LICENSE.

If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

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.

Applicant Name Sabrina N. Wyatt, M.D. (4)

The applicant Sabrina Noel Wyatt, M.D.
(PRINT OR TYPE YOUR NAME)

being first duly sworn upon his oath deposes and says: that I am the person herein named subscribing to this application; that I have read the statutes and rules regarding licensure and have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am 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 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 Medical Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Arizona Medical Board or its successors to release to the organizations, individuals or groups listed above any information which is material to the 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.

Under penalty of perjury I certify I am a U.S. Citizen or a qualified/registered alien.

Signature of Applicant Sabrina N. Wyatt, **M.D.** **Date** 2/18/08

If you would like to designate/authorize ONE other individual beside yourself to check the status of your application with the AMB, please complete the following information:

Entity name:_____ Individual Name_____ Phone #_____

*** ARIZONA LAW REQUIRES AN APPLICANT WHO HAS BEEN CHARGED WITH A FELONY OR A MISDEMEANOR INVOLVING CONDUCT THAT MAY AFFECT PATIENT SAFETY AFTER SUBMITTING THE APPLICATION TO NOTIFY THE AMB WITHIN 10 DAYS AFTER THE CHARGE IS FILED. ARIZONA REVISED STATUTE (A.R.S.) §32-3208 (SEE WEBSITE UNDER *Physician Center – Reportable Misdemeanors* FOR LIST OF REPORTABLE MISDEMEANORS – ALL FELONIES ARE REPORTABLE.)**

FOR OFFICIAL USE ONLY

Application Processed by Susan W. 3/28/08

Application Approved 5/20 2008 by Suzann Grabe

License Issued 6/10/08 JG License Number 40334

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Alabama School of Medicine

Complete Address: 1530 3rd Avenue South, VH-100

Street Address: 1670 University Blvd

City: Birmingham **State:** AL **ZIP Code (Postal Code):** 35294-0019

If name of institution was different when this individual attended, please note this name below:

Premedical Education:

Years of education required for admission to your medical school: 4

Credential/degree presented by the applicant for admission to your medical school: Bachelor of Science

Enrollment and Participation: Our records indicate that Sabrina Noel Wyatt (type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 413 Instructional weeks weeks of medical education on the following dates (mm/dd/yy):

From 07 (Month) / 26 (Date) / 1999 (Year) **To** 06 (Month) / 05 (Date) / 2004 (Year)

This individual (check one):

[X] was awarded the degree of Doctor of Medicine on 06 (Month) / 05 (Date) /2004 (Year)

[ ] was NOT awarded a degree (please attach an explanation)

Certification: By my signature, I, Linda McCullough (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

SEAL VERIFIED

Affix Institutional Seal Here.

If no seal is available, this form must be notarized.

Signature: Linda McCullough MD

Title: Registrar

Date of Signature: April 28, 2008

Phone: (205) 934-4964 **Fax:** (205) 934-8724

Email:

87985 LMD 001010

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☐ NO ☒

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☒

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response [redacted]

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
   Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Federation of STATE MEDICAL BOARDS

F[redacted]ation Credentials Verification Service (FCV[redacted])
[redacted]deration Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: University of Florida

Address: Department of Obstetrics and Gynecology
Gainesville, FL 32610-0294

Attention: **Program Director**

Affiliated University: University of Florida

Verification For:

Name: **Sabrina Noel Wyatt**

DOB: [redacted]

Individual's Name on Record (If different from above): _____

RECEIVED
APR 07 2008
By _____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate 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.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1
☒Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: OB/GYN
From: 06/28/2004 To: 06/27/2005
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: 2-3
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: OB/GYN
From: 06/28/2005 To: 06/27/2007
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: 4
☐Internship ☐Residency ☒Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: OB/GYN
From: 06/28/2007 To: 06/27/2008
Successfully Completed?: ☐Yes ☐No ☒In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐Yes ☑No
2. Was this individual ever placed on probation? ☐Yes ☑No
3. Was this individual ever disciplined or placed under investigation? ☐Yes ☑No
4. Were any negative reports for behavioral reasons ever filed by instructors? [redacted]
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐Yes ☑No

Please explain any "Yes" response from above:

SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Patrick Duff, M.D.
Signature: Patrick Duff, M.D. Patrick Duff
Title: Professor & Residency Program Director
Date of Signature: March 29, 2008
Tel: 352-273-7673 Fax: 352-392-2808 E-Mail: duffp@obgyn.ufl.edu

87985 LMD 2261

USMLE
United States Medical Licensing Examination™

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, PO Box 619850, Dallas, TX 75261-9850 – Telephone (817) 868-4041

Date: 03/25/2008

Recipient:
Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 87985

Examinee: Wyatt, Sabrina Noel
Alt Name(s):

Examinee ID#: 5-092-139-4
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, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/05/2001	Pass	188	182	77	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	07/14/2003	Pass	233	182	94	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
FLORIDA	08/12/2005	Pass	214	184	88	75	

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

LMD

PD
CC

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 • E-Mail: questions@azmd.gov

JUN 0 9 2008

May 21, 2008

Sabrina Noel Wyatt, MD
[redacted]

Dear Dr. Wyatt,

The Arizona Medical Board is pleased to inform you that your application for licensure in the State of Arizona is administratively complete and has been approved. Your license will be issued upon receipt of the required statutory license registration fee A.R.S. 32-1436(A)(2) and **is renewable on your birthday on** [redacted]

As of January 2001 Arizona converted to biennial licensure based on birth month and odd or even birth year. **Your required license registration fee is $83.33.** This fee is your licensing fee and is in addition to the $500.00 application processing fee that you have already paid.

Please complete the bottom portion of this letter and return the completed form with the initial license registration fee payable to the Arizona Medical Board, 9545 E. Doubletree Ranch Rd., Scottsdale, AZ 85258. If paying by credit card, the completed form along with the payment card authorization must be returned. NOTE: The residential address and phone number are not available to the public unless they are the only address and number of record. You are not permitted to commence the practice of medicine in the State of Arizona until your license has been issued. **Allow up to 5 business days for the processing of your payment and issuance of your license. Please do not call and request status, as this will slow down the process.**

Registration forms and initial license fees not returned **postmarked within thirty-five days** of this notice will result in the application being withdrawn and applicant will be required to reapply.

If you have any questions, please contact me by e-mail at sgrabe@azmd.gov or by telephone at (480) 551-2756.

Sincerely,

Suzann Grabe
Licensing Office Manager

(DO NOT DETACH)

Name: Sabrina Noel Wyatt
Current Office Address: P.O. Box 142113 Gainesville, FL 32610
Current Home Address: [redacted]
Current Mailing Address: [redacted]
Current Office Telephone [redacted] Current Home Telephone [redacted]
Current Office E-Mail [redacted] Current Home E-Mail [redacted]
Area of Interest: OB&GYN Practicing: ☒ Yes ☐ No (Florida)

NOTE: Statutes require you to provide the Board with written notification within thirty days (30) of any changes in addresses or phone numbers.

#40534 6/10/08

6/5
06-09-08

2.9

Please mail or fax this form to:

Arizona Medical Board
Arizona Regulatory Board of Physician Assistants
Attention: Licensing Office
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258
Fax: 480-551-2704

ADDRESS CHANGE FORM

- You must notify the board in writing within 30 days of any change of office or home address and phone number
- Failure to do so may result in a monetary fine of $100 plus the costs incurred by the Board to locate you
- Please print this from and provide all information on your address change as requested below. Please type or print legibly. Fax or mail the completed form to the Board
- In accordance with A.R.S. §32-3801, notwithstanding any law to the contrary, a professional's residential address and residential telephone number or numbers maintained by the professional board established pursuant to this title are not available to the public unless they are the only address and numbers of record.

Please record the following address changes: **EFFECTIVE DATE:** 10/15/08

PRACTICE: Maricopa Obstetrics and Gynecology Assoc. (Company Name) (If you do not have a practice address or name write the word "NONE")

Street Address Only: 1061 E. Camelback Rd, Suite 160 ***(list P.O. Box as Mailing Address below)****

City: Phoenix **State:** AZ **Zip:** 85016

Office Telephone: 602-241-1671 **Office Fax:** 602-230-7982

Office E-Mail:

RESIDENCE ADDRESS: [redacted]

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

Telephone: [redacted] **Cell Phone:** [redacted]

Residence E-Mail: [redacted]

MAIL SHOULD BE SENT TO MY: Practice ☑ Residence ☐ The Address Below ☐

MAILING ADDRESS:
(If different from either above)

Street or P.O. Box:

City: **State:** **Zip:**

****If no practice address, do you want your home address listed on the website?** Yes ☐ No ☐

Sabrina N. Wyatt
Name (Please print)

40334
AZ License #

Sabrina N Wyatt
Signature

1/30/09
Today's Date

147

Please mail or fax this form to:

Arizona Medical Board
Arizona Regulatory Board of Physician Assistants
Attention: Licensing Office
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258
Fax: 480-551-2704

ADDRESS CHANGE FORM

- You must notify the board in writing within 30 days of any change of office or home address and phone number
- Failure to do so may result in a monetary fine of $100 plus the costs incurred by the Board to locate you
- Please print this from and provide all information on your address change as requested below. Please type or print legibly. Fax or mail the completed form to the Board
- In accordance with A.R.S. §32-3801, notwithstanding any law to the contrary, a professional's residential address and residential telephone number or numbers maintained by the professional board established pursuant to this title are not available to the public unless they are the only address and numbers of record.

Please record the following address changes: **EFFECTIVE DATE:** 7/1/08

PRACTICE: Maricopa Obstetrics and Gynecology Associates (If you do not have a practice address or name write the word "NONE")
(Company Name)

Street Address Only: 1061 E. Camelback Road Suite 160
(list P.O. Box as Mailing Address below)*

City: Phoenix **State:** AZ **Zip:** 85016

Office Telephone: 602-241-1071 **Office Fax:** 602-230-7982

Office E-Mail:

RESIDENCE ADDRESS: [redacted]

City [redacted] **State** [redacted] **Zip** [redacted]

Telephone: [redacted] **Cell Phone:** [redacted]

Residence E-Mail: [redacted]

MAIL SHOULD BE SENT TO MY: Practice ☒ Residence ☐ The Address Below ☐

MAILING ADDRESS:
(If different from either above)

Street or P.O. Box:

City: **State:** **Zip:**

****If no practice address, do you want your home address listed on the website?** Yes ☐ No ☐

Sabrina Noel Wyatt, MD
Name (Please print)

40334
AZ License #

Signature

7/14/08
Today's Date

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

August 15, 2012

Sabrina Noel Wyatt M.D.
[redacted]

Re: Sabrina Noel Wyatt MD
Case # MD-12-0734D

Dear Dr. Wyatt:

The Arizona Medical Board has thoroughly investigated this case and found no violation of the Medical Practice Act. Therefore, this case has been dismissed.

Thank you for your cooperation through the course of this investigation.

Sincerely,

Lisa S. Wynn
Executive Director

BIENNIAL MD LICENSE RENEWAL APPLICATION

(Please Type in Spaces Provided)

$500 CK 4008816

RECEIVED

SEP 03 2010

AZ MEDICAL BOARD

☒ **License Fee: $500** (If postmarked by due date) 9/27/10

☐ **$850** if postmarked 30 days after due date

[redacted]

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

First Name: Sabrina **Initial:** N. **Last Name:** Wyatt

License Number: 40334

[redacted]

Practice Name: Arizona OB/Gyn Affiliates, P.C.

Office Address: 1661 E. Camelback Rd, Suite 160 **City:** Phoenix **State:** AZ **Zip:** 85016

Email: [redacted] **Office Phone:** +1 (602) 241-1671 **Office Fax:** +1 (602) 230-7982

Mailing Address: 1661 E. Camelback Rd, Suite 160 **City:** Phoenix **State:** AZ **Zip:** 85016

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

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

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

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
Obstetrics & Gynecology	☐ Yes ☒ No	☒ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

☒ **I am a U.S. Citizen or U.S. National.** (If you have not provided the Board with a copy of one of the documents listed in the Statement of Citizenship and Alien Status (i.e. birth certificate, passport, etc) since 2008, please submit a copy with your application.

☐ **I am NOT a U.S. Citizen or U.S. National.** (If this box is checked, you must download, complete and submit with your application an "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents, such as an Alien Registration Card, Visa, etc.)

☒ I am aware that it is unprofessional conduct to fail to have a written protocol in place for the secure storage, transfer and access of patient medical records when a physician terminates or sells his/her practice and the medical records do not remain in the same physical location. I have a protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close, as required by A.R.S. §32-3211.

☒ I have completed a minimum of 40 hours CME during the two previous calendar years of renewal year as required by A. R.S. §32-1434 and A.A.C. §R4-16-101.

****Please do not submit proof of CME unless you received notice on your renewal that you are subject to a CME audit. If an audit was indicated, please submit the CME documentation with your completed renewal.*

☐ **I request INACTIVATION of my medical license.** I am not presently under investigation by the Board, the Board has not commenced disciplinary proceedings against me, and *I am totally retired from the practice of medicine in this state or any state, territory, or district of the United States or foreign country*. I understand that once inactive status is granted, the Board will waive the annual renewal fees and requirements for CME. I understand that I may not engage in the practice of medicine, hold registration with the Drug Enforcement Administration, or write prescriptions as long as my license is classified as inactive. I further understand that if I request reactivation of my license, the Board may require me to pass the SPEX and any combination of physical, psychiatric, or psychological examinations or interviews it deems necessary to determine my ability to safely engage in the practice of medicine. A.R.S. §32-1431.

☐ **I request CANCELLATION of my medical license.** I am not presently under investigation by the Board, the Board has not commenced disciplinary proceedings against me, and I am no longer practicing medicine in Arizona.

QUESTIONNAIRE

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

[redacted]

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

First Name: Sabrina **Initial:** N. **Last Name:** Wyatt

License Number: 40334

CONFIDENTIAL QUESTIONNAIRE

[redacted]

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

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

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

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

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

[redacted]

☒ **I ATTEST THAT ALL INFORMATION SUBMITTED ON AND WITH THIS RENEWAL APPLICATION IS TRUE.** This includes information and responses provided on all four pages of the renewal application, any corrections made to the enclosed physician profile, and any information provided on or submitted with the CME Audit Form.

First Name: Sabrina **Initial:** N. **Last Name:** Wyatt

Signature: Sabrina N Wyatt **License Number:** 40334

[redacted]

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 40334 — Renewal Fee: $500 $850 (if postmarked 30 days after due date)

Name: Sabrina N. Wyatt, MD

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
PUBLIC ADDRESS & PHONE NUMBER

1661 E. CAMELBACK RD. #160
PHOENIX, AZ 85016

Phone #: 602-241-1671 Fax #: 602-230-7982

E-Mail: [redacted]

MAILING ADDRESS

1661 E. CAMELBACK RD. #160
PHOENIX, AZ 85016

HOME ADDRESS [redacted]

SEP 11 2008

Phone #: [redacted]

Mobile #: [redacted]

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

Field of Practice Code (see attached form for code)	ABMS Certified? (Y/N)	Practicing? (Y/N)	Expiration Date (or indicate lifetime certificated)
OBG	N	Y	written exam taken - pending oral

REQUEST FOR CHANGE IN LICENSE STATUS:

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

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

- I have completed a minimum of 40 credit hours of continuing medical education during the previous two calendar years of my renewal as required by A.R.S. §32-1434 and A.A.C. § R4-16-101
- I have a written protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close as required by A.R.S. §32-3211

☑ **I am a U.S. Citizen or U.S. National** (If this box is checked please submit with your application a copy of one of the listed approved supporting documents listed in the "Arizona Statement of Citizenship and Alien Status for State Public Benefits" i.e. Birth Certificate, U.S. Passport, etc.)

☐ **I am NOT a U. S. Citizen or U.S. National** (If this box is checked you must download, complete and submit with your application "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents i. e. Alien Registration Card, Visa, etc.)

Sabrina N. Wyatt — 9/9/08

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

ENTERED SEP 11 2008

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

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

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

Name: Sabrina N. Wyatt, MD License Number: 40334

Signature: Sabrina N Wyatt MD

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

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

[redacted]

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

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

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

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

Name: Sabrina N. Wyatt, MD License Number: 40334

Signature: Sabrina N Wyatt MD