ARIZONA BOARD OF MEDICAL EXAMINERS

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

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE THROUGH ENDORSEMENT

FOR BOARD USE
DO NOT USE THIS SPACE FEB 28 1989

BOMEX

MAR 9 1989

ALL FORMS PROVIDED MUST BE COMPLETED BY THE APPROPRIATE AGENCY AND RETURNED DIRECTLY TO THIS BOARD

INFORMATION

All candidates shall provide satisfactory evidence that

1. He possesses a good moral and professional reputation
2. He is physically and mentally able to engage safely in the practice of medicine.
3. He has not been found guilty of any act of unprofessional conduct; medical incompetency, or mentally or physically unable to engage safely in the practice of medicine
4. He has not had disciplinary action taken against him by any other state, territory, district or country for reasons relating to his ability to engage safely and skillfully in the practice of medicine.

NOTE: Applications are processed on a first-come first-served basis; the processing of a routine application can take 14 to 18 weeks.

Applications not fully complete within one year from date of receipt, including participation in an oral examination, if applicable, are considered withdrawn.

APPLICATION INSTRUCTIONS
(Read Carefully)

In addition to the appropriate completion of the applicable sections of this application; the applicant will submit the following:

1. Evidence of name and date of birth (a) a photocopy of birth certificate, or (b) an original Certificate of Naturalization; or (c) other documentary evidence for consideration (Visa, green card, Passport, etc)
2. Certified evidence of any legal name changes other than that shown on certificates filed in accordance with paragraph 1 above, (e g , marriage certificate)
3. Photocopy of M.D Degree Diploma, OR M B , B.S Degree Diploma for foreign graduates
4. Photocopy of the DD 214 Form of release from the U S. military or public health service OR, if currently serving, have attached herewith a letter from any Commanding Officer setting forth the dates of active duty, assignments, and anticipated date of release from active duty
5. Photocopies of any certificates awarded by any of the American medical specialty boards
6. Photocopies of all certificates awarded upon completion of any internship, residency, fellowship or other post-graduate medical education undertaken in United States or Canadian hospitals, OR letters of certification of partial; past, or current training.
7. The name and address of all of the following
   (a) The secretary of the county medical society where you practiced for the three years prior to filing this application, and
   (b) All of your hospital affiliations for the five years prior to filing this application and the Chief of Staff or Chief of Service for each
8. A statement of your exact whereabouts and nature of practice from date of graduation from medical school to the present, with specific month and year listed for each location No period unaccounted for is allowed

9 Cashier's Check or Money Order in U.S. Funds (personal checks not accepted), covering the statutory fee of $450 00 There are no refunds

10 Applicants, whose written examination, FLEX examination, National Board of Medical Examiners (NBME) or Licensing Medical Council of Canada (LMCC) certificates, upon which endorsement is sought was received more than fifteen years preceding the filing of this application, are required to submit to oral examination in their specialty field of practice

11 Credentials submitted in foreign languages shall have affixed thereto a certified translation into English

12 Separated or Mutilated Applications are not acceptable and will require refiling.

13 Requests for exemptions or waivers of any portion of this application will be denied and will delay your consideration for licensure

14 **NOTE:** All credentials submitted must remain the property of the Arizona Board of Medical Examiners and NONE will be returned except original Certificates of Naturalization or the applicant's **triplicate** copy of Declaration of Intention

15 Photocopies shall not exceed 8½ inches by 11 inches in size

UNITED STATES OR CANADIAN MEDICAL SCHOOL GRADUATES

Graduates of medical schools located in the United States or Canada which were approved by the Council on Medical Education of the American Medical Association, the Canadian Medical Council, or the Association of American Medical Colleges, will forward forms numbered I, II, and III to the appropriate agency with the request that they be completed and returned directly to the Arizona Board of Medical Examiners

ALL OTHER MEDICAL SCHOOL GRADUATES

Graduates of medical schools located outside the United States or Canada will forward Forms numbered I, II, III, and IV as may be applicable, to the appropriate agency with the request that they be completed and returned to the Arizona Board of Medical Examiners

Note Applications will not be processed nor considered until ALL required forms are completed and returned directly to the Arizona address provided.

APPLICATION

(To be completed, signed by applicant and notarized. All questions MUST be answered completely)

1 Present Legal Name PRINT OR TYPE — Watson, (Last) Edward (First) Ray (Middle) (Maiden)

(a) Other names used None Social Security No [redacted]

2 Address Residence [redacted] (No.) (Street) (City) (State) (Zip Code) (Phone)

Office 400 W. Main St. Suite 200 Aspen, CO. 81611 (No.) (Street) (City) (State) (Zip Code) (Phone)

3 City and State of Birth [redacted] Month, Day and Year of Birth [redacted]

4 In what states or provinces have you applied for or been granted license or registration? If more than two, attach separate listing If license not issued, so state

(a) Florida license granted Oct. 9th, 1979 #035674
(Specify State Board) (Date of Application) (Result) (Certificate No.)

Original license based on National Boards
(Date Issued) (Specify if by Written Examination or on Credentials)

(b) Colorado 7/87 granted #28473
(Specify State Board) (Date of Application) (Result) (Certificate No.)

Oct. 8th, 1987 Credentials
(Date Issued) (Specify if by Written Examination or on Credentials)

5 Have you ever had an application for a license to practice medicine denied or rejected by another state/province licensing Board? NO (Answer)

6 Have any actions, restrictions, or limitations ever been imposed on you while participating in any type of training program? NO (Answer)

7 Have you ever been charged with a violation of any statute, rule or regulation of any domestic or foreign governmental agency? NO (Answer)

8 Has there been any action initiated against you by or through any medical board or association? NO (Answer)

9 Have you ever had a medical license revoked; suspended, limited; restricted, placed on probation, voluntarily surrendered or cancelled during an investigation or in lieu of disciplinary action, or entered into a consent agreement or stipulation? NO (Answer)

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

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

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

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

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

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

16 Are you suffering from any ailment communicable to others?

Note In the event the response to any of the questions numbered 5 through 16 is YES, the applicant will file with the application a detailed report concerning the above matters, including, any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the results of any hearings, and the disposition of such charge(s) Provide the name and address of applicant's insurance carrier and the name and address of patient's attorney IN ADDITION, the applicant must provide that certified photocopy(ies) of any hearings, settlements or judgements be submitted to this Board [redacted]

17 Are you presently in good physical and mental health?

(If NO, applicant shall file with this application, a detailed statement of his health, diagnosis and prognosis, supported by report of his attending physician.)

18 Enter your height here 6'2" weight 180 color of eyes BL color of hair BR

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

Internship- University of Miami-Jackson Memorial Medical Center
Dept. of Obstetrics & Gynecology 1978-1979
Residency- University of Miami-Jackson Memorial Medical Center
Dept. of Obstetrics & Gynecology 1979-1982

20 Are you American Board certified? YES Specialty Amer. Board OB-GYN

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

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

At Residency Miami, FL (City / State) from 06/1978 to 07/1982

At Private Practice Miami Beach (City / State) from 07/1982 to 05/1988

At Priv. Practice Aspen, CO (City / State) from 06/1988 to Present

At _____ (City / State) from _____ to _____

At _____ (City / State) from _____ to _____

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

_____ Where? Tuscon

Solo or in Association with? Univ. of Arizona

24 What is your intended specialty practice? Gynecology with possible Gynecological US Fellow

25. What branch of the United States Armed Forces have you served with, if any, including USPHS? None

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

STATE OF Colorado

County of Pitkin } ss

The applicant Edward R. Watson M.D.
(PRINT OR TYPE) (Name in Full)

being first duly sworn upon his oath deposes and says that he is the person herein named subscribing to this application; that he has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he is the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Arizona Board of Medical Examiners or its successors any information, files or records requested by that Board in connection with this application, or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine I further authorize the Arizona Board of Medical Examiners or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued

Signature of Applicant E. R. Watson, M.D

(NOTARIAL SEAL)

Subscribed and sworn to before me this 7th day of March 1989

Notary Signature Kirsti Case
(Notary Public)

My Commission expires June 6, 1992

BOMEX

MAR 9 1989

FOR OFFICE USE ONLY

Application Rec'd _____ 19 _____

Application Completed 5/12 19 89

Form No I Rec'd 3/20 19 89

Form No II Rec'd 3/10 19 89

Form No III Rec'd 3-15 19 88

Form No III Rec'd N/A 19 _____

Form No III Rec'd N/A 19 _____

Form No IV Rec'd N/A 19 _____

Investigation Completed _____ 19 _____

Application Processed by cf

Application Checked by ce

Application Approved May 15 19 89

By Carol Cummings, Mgr.

License Issued June 2 19 89

License No 18821

Application withdrawn _____
(Date)

Refund must be claimed by _____
(Date)

Warrants issued _____
(Numbers and Dates)

Warrants mailed _____
(Date)

Warrants cashed _____
(Date)

EDWARD R. WATSON, M.D., F.A.C.O.G.
DIPLOMAT, AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
FELLOW, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
POST OFFICE BOX F-3
ASPEN, COLORADO 81612
(303) 920-4521
(303) 925-8063

Board of Medical Examiner's
State of Arizona

To whom it may concern,

As requested the name and address of the secretary of my county medical society is listed below.

Dolores M. Bennett
Secretary Western Slope Medical Societies
1120 Wellington, Suite 206
Grand Junction, CO 81501
(303) 243-2808

If further information is needed please do not hesitate to contact me at the above address.

Sincerely,

Edward R. Watson M.D.

HOSPITAL AFFILIATION:

✓ MOUNT SINAI MEDICAL CENTER, MIAMI BEACH, FL 5/10/89

✓ PARKWAY REGIONAL MEDICAL CENTER, MIAMI, FL 3/20/89

✓ ASPEN VALLEY HOSPITAL, ASPEN, CO 3/20/89

BOMEX

MAR 9 1989

American Board of Obstetrics and Gynecology

DIPLOMATE

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY-OBSTETRICS
CERTIFIES THAT

EDWARD R. WATSON

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC. HE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT HE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HIS PROFICIENCY IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED AND HE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD

MAR 9 19[illegible]

DECEMBER 7, 1924

AMERICAN BOARD OF MEDICAL SPECIALTIES

PRESIDENT — EXECUTIVE DIRECTOR

Roy M. Pitman — Charles B. Hammond M.D. — Gloria E. Sato M.D.

C.D. Christian — Jan M. Ingra M.D. — Ruth W. Schwartz

Wm H. Isaacs, M.D. — Fred O. Jagnese — William M. Spellberg

M.D. and D.M.D. — David M. Kelly — Luther M. Talbert

Henry Higgins

The University of Miami School of Medicine

Jackson Memorial Hospital

and

Affiliated Hospitals

Miami, Florida

Be it Known That

Edward R. Watson, M.D.

having served in the capacity of

Chief Resident in Obstetrics & Gynecology

from 1st July 1981 to 30th June 1982 and having performed his duties faithfully and satisfactorily is granted this certificate.

In Witness Whereof we have affixed our hands and the seal of the Hospital on this 30th day of June A. D. 1982

Bernard Fogel
Dean of the School

Fred J. Cowell
President, Public Health Trust of Dade County

William A. Hirst.
Chief of Service

BOARD

MAR

The University of Miami School of Medicine

Jackson Memorial Hospital

and

Affiliated Hospitals

Miami, Florida

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Edward R. Watson, M.D.

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Resident in Obstetrics & Gynecology

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Bernard Fine
Dean of the School

William A. Hines
Chief of Service

Fred J. Cowell
Director Public Health Service

BOMEX

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Photo on back

FORM I

MEDICAL COLLEGE CERTIFICATION

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the medical school granting the medical degree. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 WEST CAMELBACK ROAD, SUITE 300 PHOENIX, ARIZONA 85015. Your early response will be appreciated.

Name: Edward R. Watson (Please Print or Type), M.D. [signature] (Signature), M.D.

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

Date: 3/7/89

(DO NOT DETACH)

(This section with a current photograph of the applicant shall be forwarded to and completed by an officer of the medical school granting the medical degree.

This is to certify that Edward R. Watson (Full Name of Student)

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

The University of Oklahoma School of Medicine (Full Name of School or College of Medicine as it appears on the Applicant's Medical degree diploma) on June 4th 1978,

that the date of his/her matriculation in medical school was August, 1973; and that he/she attended all required (Number) full courses of medical lectures comprising all required (Number) months each as verified by the attached certified copy of his/her transcripts.

1. Was applicant ever required to repeat any segment of training? No If YES, which part(s)? _____

2. Was applicant ever placed on probation, restricted or limited? No If YES, please attach written explanation.

3. Was there any reason not to continue applicant in the training program? No If YES, please attach written explanation.

4. Was applicant ever known to use or misuse any chemical substance or substances which required treatment or counseling? [redacted] If YES, please attach written explanation.

5. Was applicant ever known to suffer from any mental health disorders which required treatment, counseling or medications? [redacted] If YES, please attach written explanation.

6. Were applicant's evaluations in every category rated satisfactory and/or above? Yes If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed Nancy K. Hall, M.D.

Nancy K. Hall, Ph.D.
Dean / President / Secretary / Registrar of Associate Dean for Admissions and Students, University of Oklahoma College of Medicine

(SEAL OF COLLEGE)

Date March 16, 1989

Address: P.O. Box 26901 Oklahoma City, OK 73190

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

BOMEX
MAR 20 1989

Revised 11/87

for completion of this form and is
nd forwarded to the Arizona Board
of Medical Examiners before any applica... may be considered.

The applicant must assume the responsibility for completion of this form and is forewarned that it must be fully completed and forwarded to the Arizona Board of Medical Examiners before any application may be considered.

Watson, Edward.

FORM III

POSTGRADUATE TRAINING CERTIFICATION

TO WHOM IT MAY CONCERN:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved post-graduate training program in the United States or Canada. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

Name: Edward R. WAtson (Please Print or Type), M.D. E.R. Watson (Signature), M.D.

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

Date: 3/7/89

(DO NOT DETACH)

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

This is to certify that Edward R. Watson (Name of Applicant in Full), M D, undertook and satisfactorily completed a full term approved program of 48 (Number) months in the: Univ. of Miami (Full Name and Complete Address of Hospital)

Jackson Memorial Hospital P.O. BOX 016960, MIiami, FL. 33101

in the field of Obstetrics & Gynecology from June 1978 (Date) to July 1982 (Date)

and that said program was approved for post graduate training during that period by the Council on Medical Education and Hospitals of the American Medical Association, or the Canadian Medical Association. YES X NO ____

1 Was applicant ever required to repeat any segment of training? No If YES, which part(s)? ____

2 Was applicant ever placed on probation, restricted or limited? No If YES, please attach written explanation.

3 Was there any reason not to continue applicant in the training program? No If YES, please attach written explanation

4 Was applicant ever known to use or misuse any chemical substance or substances which required treatment or counselling? [redacted] If YES, please attach written explanation.

5 Was applicant ever known to suffer from any mental health disorders which required treatment or counselling? [redacted] If YES, please attach written explanation.

RCVD MAR 15 1989

6 Were applicant's evaluations in every category rated satisfactory and/or above? Yes If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed W. Little
William A. Little, M.D.

Title Chief of Service

Address 1611 N. W. 12 Ave. Miami, Fl. 33175

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

Date 3/13, 19 89

Watson, Edward.

NATIONAL BOARD OF MEDICAL EXAMINERS® 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Edward R. Watson, M.D.

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

Attest WILLIAM B. HOLDEN, M.D.
Chairman of the Board

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

Philadelphia, Pa
07/02/79

Certificate # 174882

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from U OKLAHOMA COLL MEDICINE in JUNE 1976 and whose birth date is [redacted] This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners The scores obtained by this physician upon which his/her certification is based are as follows.

	Standard Score	Scale Score
PART I passed 09/76		
Anatomy	405	75
Physiology	530	82
Biochemistry	590	86
Pathology	585	86
Microbiology	530	82
Pharmacology	540	83
Behavioral Sciences	585	86
TOTAL TEST (Minimum Passing Score 380/75	545	83
PART II passed 04/78		
Internal Medicine	370	76
Surgery	375	76
Obstetrics and Gynecology	460	80
Public Health and Preventive Medicine	475	81
Pediatrics	430	79
Psychiatry	380	76
TOTAL TEST (Minimum Passing Score 290/75	395	78
PART III passed 03/79		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75	400	78.5
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		79.8

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

Melanie Valente
Secretary for Certification
03/06/89

SEAL

Date

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

SATISFACTION OF REQUIREMENTS SUMMARY

ENDORSEMENT

APPLICATION Received March 9, 1989

NAME IN FULL WATSON EDWARD RAY

Current Address [redacted]

Telephone (303) 920-4521

BIRTHPLACE [redacted] (Office) **Date:** [redacted]
(City) (State) (Country)

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

MEDICAL EDUCATION

University of Oklahoma College of Medicine Oklahoma City, OK 039-01
(Full Name and Location of Medical School)

M.D. Awarded: June 4, 1978 **Proof Received:** 3/20/89 ☒ **Approved**

ECFMG Certificate No. **Dated:** **Proof Received:**

Form III/Photo

POSTGRADUATE TRAINING

In OBG (Field of Training) **for** 48 **months at** Jackson Memorial Hospital Miami, FL (Name of Institution)
From July 1, 1978 **to** June 30, 1982

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

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

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

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

AMERICAN BOARD

Of OBG (30) (Specialty) **Certificate No.** **Issued** 12/7/84

Of photo (Specialty) **Certificate No.** **Issued**

PRACTICE

Field of GYN (Current)

Form II

LICENSES

Endorsement through National Board ; **No.** 174882 (Certificate) ; **Issued** 7/2/79 (Date) W/E

Florida#035674, 10/9/79 ; [ ] W/E [X] **Reciprocity With** National Board

In Colorado#28473, 10/8/87 ; [ ] W/E [X] **Reciprocity With** National Board

In ; [ ] W/E [ ] **Reciprocity With**

In ; [ ] W/E [ ] **Reciprocity With**

In ; [ ] W/E [ ] **Reciprocity With**

In ; [ ] W/E [ ] **Reciprocity With**

In ; [ ] W/E [ ] **Reciprocity With**

In ; [ ] W/E [ ] **Reciprocity With**

In ; [ ] W/E [ ] **Reciprocity With**

(TUMBLE)

U.S. MILITARY OR PUBLIC HEALTH SERVICE	**Served in** NONE (Branch)	**From**	**to**
	Honorable Discharge Received	**Discharge Rank**	
PREVIOUS PRACTICE	**In** Miami(residency)FL	**From** July 1 19 78	**to** June 30 19 82
	In Miami Beach, FL	**From** July 19 82	**to** May 19 88
	In Aspen, CO	**From** June 19 88	**to** Date 19 89
	In	**From** 19	**to** 19
	In	**From** 19	**to** 19
	In	**From** 19	**to** 19
	In	**From** 19	**to** 19
	In	**From** 19	**to** 19
	In	**From** 19	**to** 19
	In	**From** 19	**to** 19
	In	**From** 19	**to** 19
	In	**From** 19	**to** 19
	In	**From** 19	**to** 19

FEES	**Temporary $**	**Receipt #**	**Examination $**	**Receipt #**
	Locum Tenens $	**Receipt #**	**Endorsement $** 450.00	**Receipt #** A 029121

INVESTIGATION	**AMA Approval**	3/10/89, record clear, N/D
	Colorado **Board Approval**	3/14/89, cert.#28473, iss.10/8/87, End., current, N/D
	Florida **Board Approval**	3/14/89, cert.#035674, iss.10/9/79, End., current, N/D
	Fed State **Board Approval**	3/17/89, Record Clear, N/D
	Board Approval	
	Board Approval	
	Board Approval	
	Board Approval	
	Board Approval	
	Board Approval	
	Board Approval	
	Board Approval	
	Ass'n Approval	
	Ass'n Approval	
	Ass'n Approval	
INTENDED LOCATION	Tucson (Univ. of Arizona)	

ct 3/14/89 3/16/89

[redacted]

FROM E.R. Watson M.D.

[redacted]

ZIP CODE [redacted]

ASPEN, CO
MAY 30
PM
1989
81611

Broadway issue
25USA

BOARD OF MEDICAL EXAMINERS

~~5060 N. 19TH AVENUE, SUITE 300~~

PHOENIX, ARIZONA 85015

JULY 1, 1993
BOARD OF MEDICAL EXAMINERS
Suite 300
Arizona 85015

A

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1990 West Camelback, Suite 401, Phoenix, Arizona 85015, (602) 255-3751

Certified Mail/Return Receipt Requested

Date: June 2, 1989

Re: License through Endorsement

Edward Ray Watson, M.D.
[redacted]

Dear Doctor:

Congratulations! Your certificate to practice medicine in Arizona, License No. 18821 issued on JUNE 2, 1989 is enclosed with your pocket registration card for the current year.

Please be advised that annual reregistration is mandatory on a calendar-year basis, with notices generally being mailed to your address of record on or about November 1 of each year. Failure to reregister will result in statutory expiration of your license. It is your responsibility to keep us informed of address changes. Please note that Arizona Revised Statutes §32-1435(B) provides that:

> "Each person holding a current license to practice medicine in this state shall promptly and in writing inform the board of his current residence and office address and of each change in his residence and office address that may later occur."

It is also the responsibility of all licentiates in practice in Arizona to report directly to the Board of Medical Examiners any misconduct, unprofessional conduct or medical incompetence on the part of your colleagues which may come to your attention. Failure to do so is actionable against your license to practice medicine. (A.R.S. §32-1451(A).

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

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

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

Cordially,

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

DOUGLAS N. CERF
Executive Director

DNC/ce
Enclosures: 4

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

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

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

3 Article Addressed to:

Edward R. Watson, MD

[redacted]

4. Article Number

522 175 ✓

Type of Service:

☐ Registered ☐ Insured
☒ Certified ☐ COD
☐ Express Mail ☐ Return Receipt for Merchandise

Always obtain signature of addressee or agent and DATE DELIVERED

5. Signature — Address

X

6. Signature — Agent

X Dyca Watson

7. Date of Delivery

8 Addressee's Address *(ONLY if requested and fee paid)*

JUN 5 1989

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

As soon as you know your new address, mail this card to all the people, businesses, and publications who send you mail.
For publications, tape an old address label over name and old address sections and complete new address.

Your Name	Print or Type—Last Name, First Name, Middle Initial: Edward R. Watson M.D. (18821)				
Old Address	No and Street: 400 W Main St.	Apt /Suite No	P O Box: F-3	R R No	Rural Box No
	City: Aspen	State: CO	ZIP Code: 81612		
New Address	No and Street: 11792 Marbelstone Ct	Apt./Suite No	P O Box	R R No	Rural Box No
	City: West Palm Beach	State: FL	ZIP Code: 33414		
Sign Here	Signature: E. R. Watson	Date new address in effect: 10/1/89	Account No. (if any): ~~Lic #~~ 18821		

PS Form 3576, Apr 1986 RECEIVER Be sure to record the above new address book at home or office

10/11/89

BOMEX
OCT 10 1989

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

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

DATE: May 15, 1989

Edward Ray Watson, M.D.
[redacted]

Re: License through Endorsement

Dear Doctor:

The Board of Medical Examiners, State of Arizona, is pleased to inform you that your application and credentials for a license to practice medicine in the State of Arizona has been approved.

Arizona Statutes provide for an initial registration of each licentiate and the certificate of license may not be issued until this is in hand.

Please complete the enclosed card and return it to the Arizona Board of Medical Examiners, 2001 West Camelback Road, Suite 300, Phoenix, Arizona 85015. The card must be in hand by Thursday of each week in order for your license to be issued the following day. DO NOT COMMENCE PRACTICE IN ARIZONA UNTIL A LICENSE NUMBER HAS BEEN ASSIGNED.

The Board publishes an annual directory of all its licentiates, which is distributed about October of each year. Information for this publication is taken from the registration card which you complete. Home addresses and telephone numbers are not published, UNLESS THIS IS THE ONLY ADDRESS WHICH YOU PROVIDE. The cut-off date for address changes for the directory is July 31 of each year. If you anticipate a move before that date, please indicate your new address(es) with the effective date as well as your current address(es).

Thank you for your cooperation.

Cordially,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Licensing Department
Encs. 3

Watson, Edward.

HOSPITAL AFFILIATION

Dear Sir:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the Medical Staff Office in each hospital where I have held privileges, consultation or teaching appointments during the five years preceding my application. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT to the BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

NAME: Edward R. Watson M.D. ,M.D. [signature] ,M.D.
(Signature)

Address: [redacted]

Mount Siani Medical Center

(DO NOT DETACH)

1. What privileges were extended to the applicant? Obstetrics & Gynecology
2. For how long? 1982-1988
3. Were any limitations imposed on such privileges? NO
   If YES, please explain. _____
4. Were staff privileges ever removed or restricted? NO
   If YES, please explain. _____

Derogatory Information, if any _____

Names of other hospital affiliations, if known: _____

(LIST NAME, CITY AND STATE)

Comments, if any: _____

Director, Medical Staff: _____

Hospital Name: Mount Sinai Medical Center

Address: 4300 Alton Road City and State Miami Beach, FL 33139

Date: May 8, 1989 Signature: [signature]
(WRITTEN)

Gina Lipianin
(TYPED OR PRINTED)

Reverse side may be used for additional space if needed

STAMP OR SEAL OF HOSPITAL
(If no seal, please indicate)

BOWEX MAY 10 1989

Mount Sinai
MEDICAL CENTER
OF GREATER MIAMI

March 2, 1989

Board of Medical Examiners
P.O. BOX 20001
Santa Fe, New Mexico 87504

RE: EDWARD R. WATSON, M.D.

This is to confirm that Edward R. Watson, M.D. was a member of the medical staff of Mount Sinai Medical Center in the Department of Obstetrics & Gynecology. Dr. Watson was on staff from March, 1982 to October 1986. His status was Associate Attending when he resigned on March 3, 1988.

If I can be of further assistance to you please feel free to call me.

Sincerely,

Gina Lipianin, CMSC
Medical Staff Office

GL/db
ms.hosapt

4300 Alton Road • Miami Beach, Florida 33140 • Telephone (305)674-2121

HOSPITAL AFFILIATION

Dear Sir:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the Medical Staff Office in each hospital where I have held privileges, consultation or teaching appointments during the five years preceding my application. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT to the BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

NAME: Edward R. Watson M.D. ,M.D. [signature] ,M.D.
(Signature)

Address: [redacted]

Parkway Regional Medical Center
(DO NOT DETACH)

1. What privileges were extended to the applicant? Gynecology
2. For how long? 1982-1988
3. Were any limitations imposed on such privileges? No!
   If YES, please explain.
4. Were staff privileges ever removed or restricted? No!
   If YES, please explain.

Derogatory Information, if any N/A

Names of other hospital affiliations, if known:
(LIST NAME, CITY AND STATE)

Comments, if any: Dr Watson resigned from staff February 1987. During his four years at PRMC he was a member in good standing.

Coordinator
~~Director~~, Medical Staff: Rita J. Sisson

Hospital Name: AMI PARKWAY REGIONAL MEDICAL CENTER

Address: 160 NW 170 Street City and State North Miami Bch, FL 33169

Date: March 15, 1989 Signature: Rita J. Sisson
(WRITTEN)

Rita J. Sisson
(TYPED OR PRINTED)

Reverse side may be used for additional space if needed

STAMP OR SEAL OF HOSPITAL
(If no seal, please indicate)

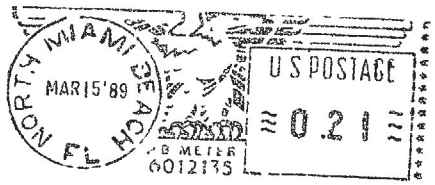
None /

BOMEX
MAR 20 1989

AMI Parkway Regional Medical Center

160 Northwest 170th Street
North Miami Beach, Florida 33169

PRESORTED
FIRST CLASS



Board of Medical Examiners
STATE OF ARIZONA
2001 West Camelback Road
Suite 300
Phoenix,
ARIZONA 85015

HOSPITAL AFFILIATION

Dear Sir:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the Medical Staff Office in each hospital where I have held privileges, consultation or teaching appointments during the five years preceding my application. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT to the BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

NAME: Edward R. Watson M.D. ,M.D. [signature] ,M.D.
(Signature)

Address: [redacted]

Aspen Valley Hospital

(DO NOT DETACH)

1. What privileges were extended to the applicant? Gynecology
2. For how long? Temp. privileges issued Oct. 5, 1988 → Courtesy Staff privileges 2-28-89
3. Were any limitations imposed on such privileges? NO
   If YES, please explain.
4. Were staff privileges ever removed or restricted? NO
   If YES, please explain.

Derogatory Information, if any None

Names of other hospital affiliations, if known:

(LIST NAME, CITY AND STATE)

Comments, if any:

Director, Medical Staff: Jack Caskey MD

Hospital Name: Aspen Valley Hospital

Address: 0200 Castle Creek Rd City and State Aspen CO 81611

Date: 3-15-89 Signature: Annette Noetzel
(WRITTEN)

Annette J. Noetzel
(TYPED OR PRINTED)

Reverse side may be used for additional space if needed

STAMP OR SEAL OF HOSPITAL
(If no seal, please indicate)

BOMEX
MAR 20 1989

Watsm, Edwand.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

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

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

Date: 2-28-89

RECEIVED
MAR 8 1989

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

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

Watson (Last) Edward (First) Ray (Middle)
Name:

[redacted]
Address

[redacted]
City, State and Zip

[redacted]
Date of Birth

[redacted]
Social Secruity Number

TAINABLE INFORMATION
OVE NAMED PHYSICIAN
1 3 1989
ALUSHA, M.D.
EXECUTIVE VICE-PRESIDENT

University of Oklahoma Okla. City, Okla.
Medical School of Graduation and Branch Location

June 4th, 1978
Date of Graduation

Please mail the response to the following:

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

Signature

SOMEX
MAR 17 1989

Executive Director
Douglas N. Cerf

Assoc. Executive Director
David O. Landrith

Manager, Licensure Dept
Carol Emminger

Telephone
(602) 255-3751

THE ARIZONA BOARD OF MEDICAL EXAMINERS

2001 west camelback road, suite 300 • phoenix, arizona 85015

March 15, 1989

Edward Ray Watson, M.D.
[redacted]

Re: License through Endorsement

Dear Doctor:

This will acknowledge receipt of your application for a license to practice medicine in Arizona through endorsement. Our receipt number A 029121 covering your fee deposit of $450.00 is enclosed, with a schedule of examination dates and filing deadlines, if applicable.

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

Form I Medical College Certification. (form enclosed) 3/20

Form III Postgraduate Training Certification from Jackson Memorial Hospital, for the period July 1, 1978 to June 30, 1982. (form enclosed) received

Verification of Licensure from Colorado and Florida. (forms enclosed) received received

Disciplinary Search from the Federation of State Medical Boards. (form enclosed) 3/17

Hospital Affiliation Forms from the following:
Mount Sinai Medical Center , Miami Beach, FL 5/10
Parkway Regional Medical Center, Miami, FL 3/20
Aspen Valley Hospital, Aspen, CO 3/20

Continued:

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

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

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

Cordially,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Carol Emminger CT

(Mrs.) Carol Emminger
Manager, Licensure Department

CE: ct

Encs. 6

Watson, Edward.

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

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

Dear Sir:

In applying for a license to practice medicine in the State of Arizona, the Medical Board requires this form to be completed by each state wherein I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise, DIRECT to the BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response is appreciated.

BOARD OF MEDICAL EXAMINERS

MAR 0 8 1989

STATE OF COLORADO

[signature] M.D.
(Signature)

Name: Edward R. Watson M.D.
(Please Print)

Address: [redacted]

My license number is: 28473

DO NOT DETACH

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

State of: Colorado

Full Name of Licensee: Edward R. Watson M.D.

Graduate of: University of Oklahoma School of Medicine

License No.: 28473 Issue date: Oct. 8th, 1987

By: Endorsement/Reciprocity with: National Boards

By: Your State Board's Written Examination/FLEX: _____

License is current? yes If NO, Why Not? _____

Has license been suspended or revoked? no If YES, Why? _____

Has licentiate ever been on probation? no If YES, Why? _____

Has licentiate ever been requested to appear before your Board? no

If YES, Why? _____

Derogatory information, if any none

Comments, if any _____

Signed: Arthur Hart

Title: Verification Clerk

State Board: Colorado

Date: 3/8/89

BOARD SEAL

BOMEX MAR 14 1989

(PLEASE USE REVERSE SIDE FOR COMMENTS)

Watson, Edward

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

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

Dear Sir:

In applying for a license to practice medicine in the State of Arizona, the Medical Board requires this form to be completed by each state wherein I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise, DIRECT to the BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response is appreciated.

RECEIVED
MAR 08 1989
MEDICAL / NATUROPATH

E. R. Watson M.D.
(Signature)

Name: Edward R. Watson M.D.
(Please Print)

Address: [redacted]

My license number is: 035674

DO NOT DETACH

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

State of: Florida

Full Name of Licensee: Edward R. Watson M.D.

Graduate of: University of Oklahoma School of Medicine

License No.: 035674 Issue date: Oct. 9th, 1979

By: Endorsement/Reciprocity with: NATIONAL BOARD

By: Your State Board's Written Examination/FLEX:

License is current? ✓ If NO, Why Not?

Has license been suspended or revoked? NO If YES, Why?

Has licentiate ever been on probation? NO If YES, Why?

Has licentiate ever been requested to appear before your Board? NO

If YES, Why?

Derogatory information, if any

Comments, if any

Signed: Allaye Lloyd - BOMEX

Title: Secretary Specialist

State Board: Florida

Date: 3/9/89

MAR 14 1989

BOARD SEAL

(PLEASE USE REVERSE SIDE FOR COMMENTS)

FEB 15 1989

Watson, Edward

(FOR OFFICE USE ONLY)

PRELIMINARY QUESTIONNAIRE

THIS IS NOT AN APPLICATION FOR LICENSE

To respond accurately to your recent inquiry, we will need the answers to *all* of the following questions to determine your eligibility for Arizona licensure. *Unless this Preliminary Form is completed in full and all questions answered, it cannot be evaluated, nor an application sent to you* Return the completed form as soon as possible to. ARIZONA BOARD OF MEDICAL EXAMINERS, 2001 West Camelback Road, Suite 300, Phoenix, Arizona 85015. PLEASE *PRINT* ALL INFORMATION.

Full Legal Name: Edward R. Watson M.D.
(FIRST) (MIDDLE) (LAST)

Current Office Address: 400 W. Main St. Suite 200

Area Code: 303

City: Aspen State: Colorado Zip Code: 81611 Phone: 925-8063

Current Residence Address: [redacted]

Area Code:

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

MEDICAL SCHOOL: Name: University of Oklahoma OK 039-01

City and State: Oklahoma City, Okla. Date of Degree: M.D. 78

If transferred from other medical school, please indicate: _____

5TH PATHWAY PROGRAM

HOSPITAL: _____ City: _____ State: _____

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

INTERNSHIP: (List U.S. & Canadian only) HOSPITAL: University of Miami Jackson Memorial City: Miami State: Fla.. OK.

Term: Started: June 78 (MONTH AND YEAR) Completed: July 79 (MONTH AND YEAR) Lyr OK.

RESIDENCY: (List U.S. & Canadian only) HOSPITAL: University of Miami Jackson Memorial City: Miami State: Fla.

Term: Started: July 79 (MONTH AND YEAR) Completed: July 82 (MONTH AND YEAR)

Specialty Field: Obstetrics & Gynecology

RESIDENCY: (List U.S. & Canadian only) HOSPITAL. _____ City: _____ State: _____

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

Specialty Field: _____

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

FOR OFFICE USE ONLY

INFORMATION FORM FORWARDED _____ 19__ BOMEX

Green. RECIPROCITY - EXAM APPLICATION FORWARDED 3-1 1989 FEB 21 1989

APPLICATION & FORMS I II III IV V VI VII NB-1 Ama. Fed St. 2 Lics. 3 Hosps.

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

CLINICAL WRITTEN EXAMINATION:

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

National Board Exam? yes Cert. No. 174882 Date Issued: July 2, 1979

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

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

If "Yes", were Flex grades obtained in one sitting? Yes _____ No _____.

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

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

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

Did you receive a minimum grade of seventy-five percent (75%)? _____

Are you a Diplomate of any of the *American* Medical Specialty Boards? Yes X No _____

If "Yes", which Board(s)? American Board of Obstetrics & Gynecology.

Have you completed the educational requirements for any of the *American* Medical Specialty Boards?

Yes _____ No _____. If "Yes", which Board(s)? _____

LICENSES: List *all* States or Provinces in which you have ever held licensure.

(1) Fla.035674 (2) CO.28473 (3) _____ (4) _____ (5) _____

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

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

Mount Siani Medical Center 4300 Alton Road, Miami Beach, Fla. 33140 1hosp.

Parkway Regional Medical Center 16800 N.W. 2nd Ave, Miami Fla. 33169 2hosp.

Aspen Valley Hospital 200 Castle Creek Road, Aspen CO. 81611 3hosp.

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

PRACTICE: City & State Where You Now Practice: Aspen, CO.

Date Above Practice Was Established: Sept. 88

CITIZENSHIP:

(X) Birth ( ) Hold Permanent Immigrant Status

( ) Naturalization ( ) Awaiting Quota Assignment

( ) Declaration of Intention

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

MILITARY (United States Only):

( ) Army ( ) Air Force

( ) Navy ( ) Marine Corps

( ) USPHS ( ) Coast Guard

Dates of Active Duty: _____

Type of Discharge. _____

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

If "Yes", indicate State/Province _____

Reason for action and action taken: _____

_____

(NOTE Attach separate sheet, if necessary)

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

If "Yes", when? _____

_____ Where? _____

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

If "Yes", when? _____

Where? & By Which Agency? _____

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

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

_____

(NOTE: Attach separate sheet, if necessary)

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

SIGNATURE E. R. Walker, M.D. DATE. 2/20/89

SOCIAL SECURITY NO. [redacted]

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

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

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

The successful passage of a FLEX Examination must be achieved at *one sitting.*

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

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

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

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

Revised 8/88

FEDERAL EXPRESS®

AIRBILL

USE THIS AIRBILL FOR DOMESTIC SHIPMENTS WITHIN THE CONTINENTAL U S A , ALASKA AND HAWAII
USE THE INTERNATIONAL AIR WAYBILL FOR SHIPMENTS TO PUERTO RICO
QUESTIONS? CALL 800-238-5355 TOLL FREE

PACKAGE TRACKING NUMBER 2197639360

2197639360

[redacted]

Date [illegible]

RECIPIENT'S COPY

1 From (Your Name) Please Print: Edward R Watson M.D
Your Phone Number (Very Important): [illegible]
Company: [illegible] Aspen
Department/Floor No:
Street Address: 410 W Main [illegible]
City: Aspen State: CO ZIP Required: 81611

2 To (Recipient's Name) Please Print:
Recipient's Phone Number (Very Important): ( )
Company: Arizona Board of Medical Examiners
Department/Floor No:
Exact Street Address (We Cannot Deliver to P O. Boxes or P O ® Zip Codes): 2001 West Camelback Rd. Suite 300
City: Phoenix State: Arizona ZIP Required: 85015

3 YOUR BILLING REFERENCE INFORMATION (FIRST 24 CHARACTERS WILL APPEAR ON INVOICE.)

PAYMENT ☐ Bill Sender ☒ Cash ☐ Bill Recipient's FedEx Acct No ☐ Bill 3rd Party FedEx Acct No ☐ Bill Credit Card

[redacted]

H IF HOLD FOR PICK-UP, Print FEDEX Address Here
Street Address
City State ZIP Required

4 SERVICES

1 ☐ PRIORITY 1 Overnight Delivery	6 ☒ OVERNIGHT LETTER*
2 ☐ COURIER-PAK OVERNIGHT ENVELOPE*	7 ☐
3 ☐ OVERNIGHT BOX	8 ☐
4 ☐ OVERNIGHT TUBE	9 ☐
5 ☐ STANDARD AIR Delivery not later than second business day	10 ☐

*Declared Value Limit $100

DELIVERY AND SPECIAL HANDLING

1 ☐ HOLD FOR PICK-UP (Fill in Box H)
2 ☒ DELIVER WEEKDAY
3 ☐ DELIVER SATURDAY (Extra charge)
4 ☐ DANGEROUS GOODS (Extra charge)
5 ☐ CONSTANT SURVEILLANCE SERVICE (CSS) (Extra charge) (Release Signature Not Applicable)
6 ☐ DRY ICE ______ Lbs
7 ☐ OTHER SPECIAL SERVICE ______
8 ☐
9 ☐ SATURDAY PICK-UP (Extra charge)
10 ☐
11 ☐
12 ☐ HOLIDAY DELIVERY (If offered) (Extra charge)

PACKAGES	WEIGHT IN POUNDS ONLY	YOUR DECLARED VALUE	OVER SIZE
Total	Total	Total	

Received At
1 ☐ Regular Stop
2 ☐ On-Call Stop
3 ☐ Drop Box 4 ☐ B S C 5 ☐ Station

FEDEX Corp Employee No [illegible]
Date/Time for FEDEX Use [illegible]

Emp No / Date
☐ Cash Received
☐ Return Shipment
☐ Third Party ☐ Chg To Del ☐ Chg To Hold
Street Address
City State Zip
Received By
X
Date/Time Received FedEx Employee Number

5 Sender authorizes Federal Express to deliver this shipment without obtaining a delivery signature and shall indemnify and hold harmless Federal Express from any claims resulting therefrom
Release Signature [illegible]

Federal Express Use
Base Charges
Declared Value Charge
Other 1
Other 2
Total Charges

PART #2041738900
REVISION DATE 10/88
PRINTED IN U S A NCREC
009

Watson, Edward R. ✓

send background form & A.G. Statutes to:

Edward R. Watson, M.D.
[redacted]

A.G. - Univ. of Oklahoma

took N.B. in July 1979 - has not been 10 years since he took his N.B.

ph

2/15/89

AG statutes

INFORMATION FORM [illegible] 2/15 19 89

National Board of Medical Examiners

of the

United States of America

Edward R. Watson, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a

Diplomate of the National Board of Medical Examiners

Attest William D. Hassan M.D.
Chairman of the Board

Edithe J. Levis
President of the Board

Philadelphia, Pa.
July 2, 1979

Certificate No. 174882

BOM
MAR

acting through the

University of Oklahoma

have admitted

Edward R. Watson

to the degree of

Doctor of Medicine

and all the honors, privileges and obligations belonging thereto, and in witness thereof have authorized the issuance of this diploma duly signed and sealed.

Issued at the University of Oklahoma on the fourth day of June, A. D., nineteen hundred and seventy-eight.

AMB - Physician Renewal - Confirmation (Step 8 of 11) 1/30/2019

Edward Ray Watson

Please review the information below and click at the bottom to accept. If you need to correct the information, click the links below the records.

General Questions

Note: ***In the event the response to any of the questions numbered 1 through 10 is â€œYESâ€***, you must file by fax or mail a detailed report concerning the below matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. IN ADDITION, you must submit photocopies of any corresponding documents, such as complaints or board actions.

1) Since your last renewal, have you had an application for medical licensure denied or rejected by another state or province licensing board? If so, provide an explanation.

No

2) Since your last renewal, has any disciplinary or rehabilitative action been taken against you by another licensing board, including other health professions? If so, provide an explanation.

No

3) Since your last renewal, have any disciplinary actions, restrictions or limitations taken against you while participating in any type of program or by any health care provider? If so, provide an explanation.

No

4) Since your last renewal, have you had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation, during an investigation or entered into a consent agreement or stipulation? If so, provide an explanation.

No

5) Since your last renewal, have you had hospital privileges revoked, denied, suspended, or restricted? If so, provide an explanation. (Do not report if your hospital privileges were suspended due to failure to complete hospital record and reinstated after no more than 90 days)

No

6) Since your last renewal, Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? If so, provide an explanation.

No

7) Since your last renewal, have you had your authority to prescribe, dispense, or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency as a result of disciplinary or other adverse action? If so, provide an explanation.

No

8) This question has been deleted

[redacted]

9) Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude (in any state) , or an alcohol or drug-related offense in any state? Is so, provide an explanation. See list of Moral Turpitude items at .

[redacted]

10) Since your last renewal, have you failed the special purpose licensing examination (SPEX)?

No

Physical/Mental Health and Substance Abuse Questions

1) Since your last renewal, have you received treatment for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narcotic or a physical, mental, emotional, or nervous disorder or condition that currently affects your ability to exercise the judgment and skills of a medical professional? If so, provide the following: A) Detailed description of the use, disorder, or condition; and B) An explanation of whether the use, disorder, or condition is reduced or ameliorated because you receive ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating. C) A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.

The purpose of the confidential question is to allow the Board to determine current fitness to practice medicine. The mere fact of treatment is not, in itself, a basis for denial. The Board often licenses individuals who demonstrate personal responsibility but may limit or deny applicants whose ability to practice is affected by a condition or who demonstrate a lack of candor in their responses. The Board encourages applicants to seek assistance if needed.

[redacted]

2) This question has been deleted.

[redacted]

Citizenship Status

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

Specialties

	Specialty	**Certified?**	**Practicing?**	**Date Certified**	**Expiration Date**
Primary Specialty	Obstetrics & Gynecology	Yes	Yes		
Specialty 2	Diagnostic Radiology (Radiology)	No	Yes		
Specialty 3					

Practice Address

Edward R Watson M.d.
5640 E Mesquite Ln
Phoenix AZ, 85018
Phone: (480) 990-2929
Fax: (480) 990-2998

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

Home Address

[redacted]

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

Mailing Address

[redacted]

Contact:
Contact Phone:
Contact Email:

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

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

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

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

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

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

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

MD Training Unit

Complete

You may wish to print this Page for your records.

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

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

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

RECEIVED
FEB 10 2017
ARIZONA MEDICAL BOARD

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

☒ License Fee $500 (if postmarked by due date)

☐ License Fee $850 (if postmarked 31 days after due date)

BEFORE COMPLETING THIS RENEWAL FORM: Please review your physician profile, located at www.azmd.gov. If any of the information is incorrect, please print a copy, line out the erroneous information, write in the correct information and submit it with your renewal. You are subject to discipline if you provide erroneous information. Please note that name changes must be made under separate cover.

NOTE: Effective February 14, 2012, the Arizona Medical Board (AMB) no longer issues **wallet cards**. A physician's AMB website profile is the most reliable way to verify current license status. The profile can be accessed at www.azmd.gov

1. First Name: Edward Initial: R Last Name: Watson

License Number: 18821

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.

2. Practice/Training Name: Edward Watson M.D.

Address: 5640 E Mesquite Dr City: Phoenix State: AZ Zip: 85018

Phone: 480-990-2929 Fax: 480-990-2998 *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.

3. Home Address: [redacted] City: [redacted] State: [redacted] Zip: [redacted]

Phone: [redacted] Mobile: [redacted]

Primary Email Address [redacted]

Mailing Address: If no address is provided, all Board correspondence will be sent to your practice address.

4. 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, 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.

Name | Phone# | E-mail

5. AREA OF INTEREST/ABMS CERTIFICATION

AMERICAN BOARD OF MEDICAL SPECIALTY (ABMS) CERTIFICATION AND FIELDS OF PRACTICE: Please review and correct the fields of practice and ABMS board certification information as shown on your profile. Only certification from the American Board of Medical Specialties will be shown. Select the fields of practice from the drop down list. If you are Board certified check "yes".

Area of Interest	Practicing?	ABMS Certified?	Expiration Date (Or indicate if lifetime certificate)
OB-GYN	☒ Yes ☐ No	☒ Yes ☐ No	Lifetime
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

6. CITIZENSHIP ATTESTATION

PROOF OF CITIZENSHIP: All applicants must provide evidence that the applicant is lawfully present in the United States.

A.R.S. 41-1080 and A.A.C. R4-16-201(C)(1) require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona.

However, if you provided documentation to the Board of your U.S. Citizenship or nationalization at the time of your last renewal or at the time of your initial application to the Board, no further documentation are required.

Alternatively, if you have become a U.S. citizen or U.S. national since the time of your most recent application with the Board or are not currently a U.S. citizen or national, you must submit proof of your current status to the Board before your license will be renewed.

Documentation can be submitted to the Board via email at Licensingreport@azmd.gov. Please see the Evidence list included with this application for a list of acceptable documents. Additionally, a notary copy of your birth certificate or passport must be submitted in accordance with R4-16-201(C)(1) if you have not previously established your citizenship or nationalization with the Board.

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

☐ I have become a U.S. Citizen or U.S. National since the time of my last renewal.

☐ I am not a U.S. Citizen or U.S. National.

First Name: Edward **Last Name:** Watson

7. PROTOCOL FOR STORAGE, TRANSFER AND ACCESS OF PATIENT MEDICAL RECORDS

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

☐ I am exempt from the records protocol requirement as outlined in A.R.S. 32-3211(G). I am a health professional who is employed by a health care institution as defined in Section A.R.S. 36-401 that is responsible for the maintenance of the medical records.

☐ I have no patient records that I am required to maintain under A.R.S. Section 12-2297 or any other statute or federal law.

Note: ARS Section 12-2297 requires the maintenance of a patient's medical records as follows: 1. If the patient is an adult, for at least six years after the last date the adult patient received medical or health care services from that provider. 2. If the patient is a child, either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services form that provider, whichever date occurs later. 3. Source data may be maintained separately from the medical record and must be retained for six years from the date of collection of the source data.

8. CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

☑ I have completed a minimum of 40 hours CME during the two previous calendar years of renewal year as required by A.R.S. § 32-1434 and A.A.C. § R4-16-101.
**Please do not submit proof of CME unless you received notice on your renewal that you are subject to a CME audit. If an audit was indicated, submit CME documentation with your completed renewal.*

9. REQUEST FOR CHANGE IN LICENSE STATUS

☐ **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.

10. Training Unit Attestation

Renewal 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 10/15/2015

Full Name (print): Edward R Watson **Signature:** 

License number: 18821 **Date:** 2/10/17

11. Questionnaire

1. Since your last renewal, have you had an application for medical licensure denied or rejected by another state or province licensing board?	☐ Yes	☑ No
2. Since your last renewal, have you had any disciplinary or rehabilitative action taken against you by another licensing board, including other health professions?	☐ Yes	☑ No
3. Since your last renewal, have you had any disciplinary actions, restrictions or limitations taken against you while participating in any program or by any health care provider?	☐ Yes	☑ No
4. Since your last renewal, 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
5. Since your last renewal, have you had hospital privileges revoked, denied, suspended, or restricted? (do not report if your hospital privileges were suspended due to failure to complete hospital record and reinstated after no more than 90 days)	☐ Yes	☑ 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 an agency of the federal or state government?	☐ Yes	☑ No
7. Since your last renewal, have you had the authority to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency as a result of disciplinary or other adverse action?	☐ Yes	☑ No
8. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, a misdemeanor involving moral turpitude, or an alcohol or drug-related offense in any state?	[redacted]	
9. Since your last renewal, have you failed the special purpose licensing examination (SPEX)?	☐ Yes	☑ No

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

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

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

[redacted]

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: Edward **Last Name:** Watson

13. Attestation

I attest that all of the information contained in the renewal application and accompanying evidence or other credentials submitted are true. This includes any corrections made to the enclosed physician profile, and any information provided on or submitted with the CME Audit Form.

First Name: Edward Last Name: Watson

Signature of Applicant: [signature] Date: 2/10/17

14. Controlled Substances Prescription Monitoring Program Registration

State law, specifically, Arizona Revised Statutes § 36-2606, requires every Arizona medical practitioner who possesses a Drug Enforcement Administration ("DEA") permit to also hold a Controlled Substances Prescription Monitoring Program ("CSPMP") registration issued by the Arizona State Board of Pharmacy ("Pharmacy Board"). The failure of a medical practitioner to obtain a CSPMP registration may result in disciplinary action by the practitioner's licensing board. See A.R.S. § 36-2607.

Arizona Revised Statutes § 32-3219, mandates the Arizona Medical Board ("Board") to notify the Pharmacy Board of newly-licensed physicians who intend to apply for a DEA permit and physicians who renew their licenses. The Board is also required to submit to the Pharmacy Board information to assist the Pharmacy Board in the registration of medical professionals for the CSPMP. To facilitate the Board's collection of this information please complete the enclosed form and submit it to the Board along with your license application/renewal application.

If you have any questions regarding the attached form, please contact the Kim Crawford, CSPMP Manager at 602-771-2732 or Elizabeth Dodge, CSPMP Director at 602-771-2744.

1. Do you currently prescribe controlled substances in Arizona?	☐ Yes ☒ No
2. Do you hold a DEA Certificate associated with a location in Arizona?	☒ Yes ☐ No
3. Are you registered with the CSPMP	☒ Yes ☐ No

THIS FORM MUST BE RETURNED TO THE ARIZONA MEDICAL BOARD IN ORDER TO COMPLETE YOUR APPLICATION.

First Name: Edward **Last Name:** Watson

Signature: [signature] **Date:** 2/10/17

[redacted]

Arizona State Board of Pharmacy

Application for REGISTRATION - Medical Practitioner and Access to the Arizona Controlled Substances Prescription Monitoring Program

FOR OFFICE USE ONLY

PRINT CLEARLY USING CAPITAL LETTERS

License Type: [X] MD [ ] MD(H) [ ] DO [ ] DO(H) [ ] DDS [ ] OMD [ ] DPM [ ] PA [ ] NP [ ] ND [ ] OD

State Licence Number: 18821

Expiration Date: 02/10/2017

*DEA Number: [redacted]

MEDICAL RESIDENTS - Add the suffix assigned to the Facility DEA# above

Expiration Date of DEA: 05/31/2019

MEDICAL RESIDENTS:

Assigned Resident License #:

Expiration Date of Resident License #: / /

NPI Number: 1952522864

SECURITY QUESTIONS:

Mother's Maiden Name: [redacted]

Your birth City: [redacted]

1. DEMOGRAPHICS

Legal First Name: Edward

Middle Name: Ray

Legal Last Name: Watson

Last 4 Digits of SSN: [redacted]

Date of Birth: [redacted]

2. PRACTICE ADDRESS

Street Address Line 1: 5640 E MESQUITE LN

Street Address Line 2:

City: PHOENIX

State: AZ Zip Code: 85018 County:

Work Phone: 480 - 990 - 2929 Fax: 480 - 990 - 2998

3. Complete If Mailing Address is NOT the same as PRACTICE ADDRESS

Street Address Line 1:

Street Address Line 2:

City:

State: Zip Code: County:

4. Medical Practitioner's - Work or Personal E-mail Address

[redacted]

*If a Medical Practitioner has multiple DEA numbers, you MUST complete one form for each DEA number

CC $500

Biennial MD LICENSE RENEWAL APPLICATION

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

RECEIVED
JAN 16 2015
ARIZONA MEDICAL BOARD

☒ **License Fee $500** (if postmarked by due date)

☐ **License Fee $850** (if postmarked after due date)

BEFORE COMPLETING THIS RENEWAL FORM: Please review your physician profile, located at www.azmd.gov. If any of the information is incorrect, please print a copy, line out the erroneous information, write in the correct information and submit it with your renewal. You are subject to discipline if you provide erroneous information. Please note that name changes must be made under separate cover.

NOTE: Effective February 14, 2012, the Arizona Medical Board (AMB) no longer issues **wallet cards**. A physician's AMB website profile is the most reliable way to verify current license status. The profile can be accessed at www.azmd.gov

First Name: Edward **Initial:** R. **Last Name:** Watson

License Number: 18821

ADDRESSES:

Practice Address: This is the practice/principal place of business. The address and phone number will appear in the Medical Directory and on the Board's web site. Every physician must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public. If you want your home address to be listed on your web site profile, please so indicate. Otherwise, no address will be be provided on the profile, but it will be provided to the public if requested.

Mailing Address: If no address is provided, all Board correspondence will be sent to the Practice Address.

Email: This address is optional. If you provide an email address, it will not be released to the public.

Home Address: You are required to provide a home address and telephone number. They will not be released to the public *unless* you fail to provide an Office Address.

Practice/Training Name: Edward R. Watson M.D. / ACFW

Practice/Training Address: 6660 SW 117th Av. **City:** Miami **State:** FL **Zip:** 33183

Practice Phone: 305-6303363 **Practice Fax:** 305-6303364

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

☐ Same as Practice Address ☐ Same as Home Address

Email: [redacted]

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

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

ENTERED

fields of practice and ABMS board certification information as shown on your profile. Only certifications from the American Board of Medical Specialties will be shown. Select the fields of practice form the drop down list. If you are Board certified, check "yes".

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
OB-GYN	☒ Yes ☐ No	☒ Yes ☐ No	Lifetime
Diagnostic Ultrasound	☐ Yes ☒ No	☒ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

PROOF OF CITIZENSHIP: All applicants must provide evidence that the applicant is lawfully present in the United States.

A.R.S. 41-1080 and A.A.C. R4-16-201(C)(1) require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona.

However, if you provided documentation to the Board of your U.S. citizenship or nationalization at the time of your last renewal or at the time of your initial application to the Board, no further documents are required.

Alternatively, if you have become a U.S. citizen or U.S. national since the time of your most recent application with the Board or are not currently a U.S. citizen or national, you must submit proof of your current status to the Board before your license will be renewed.

Documentation can be submitted to the Board via email at Licensingreport@azmd.gov. Please see the Evidence List on the Board's website (www.azmd.gov) for a list of acceptable documents. Additionally, a certified copy of the birth certificate or certified copy of the passport must be submitted in accordance with R4-16-201(C)(1) if you have not previously established your citizenship or nationalization with the Board.

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

☐ **I have become a U.S. Citizen or U.S. National since the time of my last renewal.**

☐ **I am NOT a U.S. Citizen or U.S. National.**

PROTOCOL FOR STORAGE, TRANSFER AND ACCESS OF PATIENT MEDICAL RECORDS

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

☐ I am exempt from the records protocol requirement as outlined in A.R.S. 32-3211(G). I am a health professional who is employed by a health care institution as defined in Section A.R.S. 36-401 that is responsible for the maintenance of the medical records.

☐ I have no patient records that I am required to maintain under A.R.S. Section 12-2297 or any other statute or federal law.

Note: ARS Section 12-2297 requires the maintenance of a patient's medical records as follows: 1. If the patient is an adult, for at least six years after the last date the adult patient received medical or health care services from that provider. 2. If the patient is a child, either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services form that provider, whichever date occurs later. 3. Source data may be maintained separately from the medical record and must be retained for six years from the date of collection of the source data.

CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

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

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

First Name: Edward **Last Name:** Watson **License Number:** 18821

form. Do not submit a license renewal fee if you are requesting inactivation or cancellation, however; you must sign and date this form.

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

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

QUESTIONNAIRE

1. Since 2009, have you had any application for medical licensure denied or rejected by another state or province licensing board? If so provide an explanation.	☐ Yes	☑ No
2. Since 2009, has any disciplinary or rehabilitative action been taken against you by another licensing board including other health professions. If so, provide an explanation.	☐ Yes	☑ No
3. Since 2009, have any disciplinary actions, restrictions or limitations been taken against you while participating in any type of program or by any healthcare provider? If so, provide an explanation.	☐ Yes	☑ No
4. Since 2009, have you had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation during an investigation or entered into a consent agreement or stipulation? If so, provide an explanation.	☐ Yes	☑ No
5. Since 2009, have you had hospital privileges revoked, denied, suspended, or restricted? If so, provide an explanation.	☐ Yes	☑ No
6. Since 2009, have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? If so, provide an explanation.	☐ Yes	☑ No
7. Since 2009, have you had your authority to prescribe, dispense, or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency? If so, provide an explanation.	☐ Yes	☑ No
8. Since 2009, have you engaged or do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication? If so, provide an explanation.	[redacted]	
9. Since 2009, have you been found guilty or entered into a plea of no contest to a felony, or a misdemeanor involving moral turpitude in any state? If so, provide an explanation. See list of Moral Turpitude items at www.azmd.gov.	☐ Yes	☑ No
10. Since 2009, have you failed the special purpose licensing examination (SPEX)?	☐ Yes	☑ No

NOTE: In the event that the response to any of the questions above is "Yes", you must file with the renewal a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. In addition, you must submit photocopies of any corresponding documents, such as complaints or board actions.

ARS 32-1430(B): A person renewing an active license to practice medicine in this state shall attach to the completed renewal form a report of disciplinary actions, restrictions or any other action placed on or against that person's license or practice by another state licensing or disciplinary board or an agency of the federal government. This action may include denying a license or failing the special purpose licensing examination. The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action taken.

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: Edward **Last Name:** Watson **License Number:** 18891

CONFIDENTIAL QUESTIONS

1. Since 2009, have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine including a diagnosis or treatment for any psychotic disorder or substance abuse disorder? If so, provide an explanation.

2. Since 2009, have you consumed intoxicating beverages resulting in your ability being impaired or limited to exercise the judgment and skills of a medical professional? If so, provide an explanation.

[redacted]

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

Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

ATTESTATION:

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: Edward **Initial:** R **Last Name:** Watson

License Number: 18821

Signature of Applicant: [signature] Date: 11/15/2015

Questions?

ARIZONA MEDICAL BOARD
CME AUDIT FORM

If your license number was selected for CME audit, as indicated on your renewal notice letter, please complete this form and submit it with your renewal application.

First Name: Edward Initial: R Last Name: WATSON

License Number: 18871

In order to maintain a medical license in the State of Arizona, per Arizona Administrative Code R4-16-101, you are required to complete at least forty (40) hours of continuing medical education during the two calendar years preceding biennial registration. Please refer to Arizona Administrative Rule R4-16-102 to identify statutorily approved CME activities. Statutes and rules are available on our web site www.azmd.gov.
Please attach to this form your proof of CME. Your renewal will not be complete until your submitted CME documentation has been reviewed by the Board.

Dates	Type of CME Activity	Number of Credit Hours
Jan 13, 2015	Pediatric Abusive head trauma	1.5
Jan 12, 2015	Cancer Screening	10
Jan 12, 2015	Prescription Opioids-Risk Mang	15
Jan 13, 2015	Child abuse ID : reporting	2
Sept 11, 2013	Chronic Pain Syndromes	15
Sept 5, 2013	Pressure Ulcers	10
Sept 4, 2013	Domestic Violence	2
Sept 4, 2013	Medical Error Prevention	2
I have also done 100 hrs of medical student teaching (Univ. of Miami) over the past 2 years		

By my signature below, I attest that the above is a true and correct representation of the Continuing Medical Education I completed during the two years preceding biennial registration.

Signature: [signature] M.D. Date: 1/15/2015

THIS FORM MUST BE RETURNED WITH YOUR RENEWAL APPLICATION

Certificate of Completion

NetCE certifies that
Edward R. Watson G66149
has participated in the enduring material titled
#92401 Pediatric Abusive Head Trauma
on January 13, 2015
and is awarded 1.5
AMA PRA Category 1 Credit(s) ™.

Freda S. O'Brien — Director of Academic Affairs

Erin K. Meinyer — Executive Director

NetCE is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Florida CE Broker Provider #50-2405, Board of Medicine.

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency. This course is designed to fulfill the Kentucky requirement for 1.5 hours of pediatric abusive head trauma continuing education.

NetCE
Continuing Education

Certificate of Completion

NetCE certifies that
Edward R. Watson 18821
has participated in the enduring material titled
#91990 Cancer Screening
on January 12, 2015
and is awarded 10
AMA PRA Category 1 Credit(s) ™.

Freda S. O'Brien
Director of Academic Affairs

Erin K. Meinyer
Executive Director

NetCE is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Florida CE Broker Provider #50-2405, Board of Medicine.

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

NetCE
Continuing Education

Certificate of Completion

NetCE certifies that
Edward R. Watson 18821
has participated in the enduring material titled
#91410 Prescription Opioids: Risk Management and Strategies for Safe Use
on January 12, 2015
and is awarded 15
AMA PRA Category 1 Credit(s) ™.

Freda S. O'Brien
Freda S. O'Brien
Director of Academic Affairs

Erin K. Meinyer
Erin K. Meinyer
Executive Director

NetCE is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Florida CE Broker Provider #50-2405, Board of Medicine.

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

NetCE
Continuing Education

Certificate of Completion

NetCE certifies that
Edward R. Watson 18821
has participated in the enduring material titled
#97531 Child Abuse Identification and Reporting: The New York Requirement
on January 13, 2015
and is awarded 2
AMA PRA Category 1 Credit(s) ™.

Freda S. O'Brien
Freda S. O'Brien
Director of Academic Affairs

Erin K. Meinyer
Erin K. Meinyer
Executive Director

NetCE is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Florida CE Broker Provider #50-2405, Board of Medicine.

This course is approved by the New York State Education Department to fulfill the requirement for 2 hours of training in the Identification and Reporting of Child Abuse and Maltreatment. Provider #80673. This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

NetCE
Continuing Education

Certificate of Completion

NetCE certifies that
Edward R. Watson G66149
has participated in the enduring material titled
#98700 Chronic Pain Syndromes: Current Concepts and Treatment Strategies
on September 11, 2013
and is awarded 15
AMA PRA Category 1 Credit(s)™.

Freda S. O'Brien
Director of Academic Affairs

Erin K. Meinyer
Executive Director

CME Resource is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Florida CE Broker Provider #50-2405, Board of Medicine.

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

NetCE
Continuing Education

Certificate of Completion

NetCE certifies that
Edward R. Watson G66149
has participated in the enduring material titled
#4885 Pressure Ulcers:
Pathogenesis and Management
on September 5, 2013
and is awarded 10
AMA PRA Category 1 Credit(s)™.

Freda S. O'Brien
Freda S. O'Brien
Director of Academic Affairs

Erin K. Meinyer
Erin K. Meinyer
Executive Director

CME Resource is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Florida CE Broker Provider #50-2405, Board of Medicine.

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

NetCE
Continuing Education

Certificate of Completion

NetCE certifies that
Edward R. Watson G66149
has participated in the enduring material titled
#9792 Domestic Violence:
The Florida Requirement
on September 4, 2013
and is awarded 2
AMA PRA Category 1 Credit(s) ™.

Freda S. O'Brien
Director of Academic Affairs

Erin K. Meinyer
Executive Director

CME Resource is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Florida CE Broker Provider #50-2405, Board of Medicine.

This course fulfills the Florida requirement for 2 hours of Domestic Violence education every third renewal period. This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

NetCE
Continuing Education

Certificate of Completion

NetCE certifies that
Edward R. Watson G66149
has participated in the enduring material titled
#91331 Medical Error Prevention
and Root Cause Analysis
on September 4, 2013
and is awarded 2
AMA PRA Category 1 Credit(s) ™.

Freda S. O'Brien
Freda S. O'Brien
Director of Academic Affairs

Erin K. Meinyer
Erin K. Meinyer
Executive Director

CME Resource is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Florida CE Broker Provider #50-2405, Board of Medicine.

This course fulfills the Florida requirement for 2 hours of education on the Prevention of Medical Errors. This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

NetCE
Continuing Education

Arizona Medical Board: License Renewal Questions

Edward Watson 2014 License # 18821 Professional Conduct

1. Since 2009, have you had an application for medical licensure denied or rejected by another state or province licensing board? If so, provide an explanation.	**No**	
2. Since 2009, has any disciplinary or rehabilitative action been taken against you by another licensing board, including other health professions? If so, provide an explanation.	**No**	
3. Since 2009, have any disciplinary actions, restrictions or limitations taken against you while participating in any type of program or by any health care provider? If so, provide an explanation.	**No**	
4. Since 2009, have you had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation, during an investigation or entered into a consent agreement or stipulation? If so, provide an explanation.	**No**	
5. Since 2009, have you had hospital privileges revoked, denied, suspended, or restricted? If so, provide an explanation.	**No**	
6. Since 2009, Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? If so, provide an explanation.	**No**	
7. Since 2009, have you had your authority to prescribe, dispense, or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency? If so, provide an explanation.	**No**	
8. Since 2009, have you engaged or do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication? If so, provide an explanation.	[redacted]	
9. Since 2009, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? Is so, provide an explanation. See list of Moral Turpitude items at www.azmd.gov.	**No**	
10. Since 2009, have you failed the special purpose licensing examination (SPEX)?	**No**	

Arizona Medical Board: License Renewal Questions

Edward	Watson	2014	License # 18821	Mental Health

1. Since 2009, have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine including diagnosis or treatment for any psychotic disorder or substance abuse disorder? If so, provide an explanation.

2. Since 2009, have you consumed intoxicating beverages resulting in your ability being impaired or limited to exercise the judgment and skills of a medical professional? If so, provide an explanation

[redacted]

Arizona Medical Board: License Renewal Questions

Edward Watson 2012 License # 18821 Professional Conduct

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

Arizona Medical Board: License Renewal Questions

Edward	Watson	2012	License # 18821	Mental Health

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

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

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

[redacted]

BIENNIAL MD LICENSE RENEWAL APPLICATION

(Please Type in Spaces Provided)

$605

RECEIVED
FEB 03 2011
AZ MEDICAL BOARD

☒ **License Fee: $500** (If postmarked by due date)

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

BEFORE COMPLETING THIS RENEWAL FORM: Please review your physician profile, located at www.azmd.gov. If any of the information is incorrect, please print a copy, line out the erroneous information, write in the correct information and submit it with your renewal. You are subject to discipline if you provide erroneous information. Please note that name changes must be made under separate cover.

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

First Name: Edward **Initial:** R **Last Name:** WATSON

License Number: 18821

ADDRESSES:

Office Address: This is the office/principle place of business. The address and phone number will appear in the Medical Directory and on the Board's web site. Every physician must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public. If you want your home address to be listed on your web site profile, please so indicate. Otherwise, no address will be be provided on the profile, but it will be provided to the public if requested.

Mailing Address: Please provide a mailing address if different from Office or Home Address. If no address is provided, all Board correspondence will be sent to the Office Address.

Home Address: You are required to provide a home address and telephone number. They will not be released to the public *unless* you fail to provide an Office Address.

Email: This address is optional. If you provide an email address, it will not be released to the public.

Practice Name: Edward Watson M.D.

Office Address: 6660 SW 117th Av. **City:** Miami **State:** FL **Zip:** 33183

Email: [redacted] **Office Phone:** 305-630-3363 **Office Fax:** 305-630-3364

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

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

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

ENTERED

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

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

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
OB-GYN	☒ Yes ☐ No	☒ Yes ☐ No	Lifetime
Diagnostic Ultrasound	☐ Yes ☒ No	☒ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

PROOF OF CITIZENSHIP: Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States. Federal law, 8 U.S.C. §1641 and State law, A.R.S. §1-501, require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona. Statement of Citizenship and Alien Status available on the website.

☒ **I am a U.S. Citizen or 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.)

PROTOCOL FOR STORAGE, TRANSFER AND ACCESS OF PATIENT MEDICAL RECORDS

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

CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

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

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

REQUEST FOR CHANGE IN LICENSE STATUS: You may request INACTIVATION or CANCELLATION of your license using this form. Do not submit a license renewal fee if you are requesting inactivation or cancellation; however, you must sign and date this form.

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

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

QUESTIONNAIRE

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

NOTE: In the event that the response to any of the questions above is "Yes," you must file with the renewal a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. In addition, you must submit photocopies of any corresponding documents, such as complaints or board actions.

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

First Name: Edward **Initial:** R **Last Name:** Watson

License Number: 18821

CONFIDENTIAL QUESTIONNAIRE

[redacted]

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

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

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

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

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

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

Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

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

First Name: Edward **Initial:** R **Last Name:** Watson

Signature: E. R. Watson M.D. **License Number:** 18821

Questions?

Arizona Medical Board: License Renewal Questions

Edward Watson 2008 License # 18821 Professional Conduct

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

Arizona Medical Board: License Renewal Questions

Edward	Watson	2008	License # 18821	Mental Health

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

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

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

[redacted]

ARIZONA MEDICAL BOARD CK-5961
2007 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 18821 Edward R. Watson, MD **Renewal Fee: $500 $850** (if postmarked after **03/10/2007**)

CURRENT INFORMATION Please review and make corrections as necessary ™	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 6660 SW 117th Ave Miami FL 33183-2826	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**
Phone #: (305) 630-3363 **Fax #:** (305) 630-3364	**Phone #:** **Fax #:**
E-Mail:	**E-Mail:** [redacted]
MAILING ADDRESS [redacted]	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** [redacted]	**Phone #:** **Fax #:**
E-Mail: [redacted]	**E-Mail:**
Mobile #:	**Mobile #:** (Optional)

RECEIVED
FEB 13 2007
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

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

	Certified?	Practicing?
OBG	Y	Y
GYN	Y	Y
DR	N	Y

Make corrections if necessary
INITIALS REQUIRED EW

	Certified?	Practicing?	Expiration Date	Initials Required

Verified Licensing ✓

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

REQUEST FOR CHANGE IN LICENSE STATUS:

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

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

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

E. R. Watson M.D. 2/12/07

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

18821 Edward R. Watson, MD

SEE REVERSE SIDE

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

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

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

18821 Edward R. Watson, MD **INITIALS REQUIRED** EW

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

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

INITIALS REQUIRED E.R.W.

ARIZONA MEDICAL BOARD
2005 BIENNIAL MD LICENSE RENEWAL APPLICATION

5651

AZ MD Lic#: 18821 Edward R. Watson, MD — **Renewal Fee: $500** — **$850** (If postmarked after 03/10/2005)

CURRENT INFORMATION Please review and make corrections as necessary ➪	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 6660 SW 117th Ave Miami FL 33183-2826	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**
Phone #: (305) 630-3363 **Fax #:** (305) 630-3364 **E-Mail:**	**Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS [redacted]	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** **E-Mail:**	**Phone #:** **Fax #:** [redacted] **E-Mail:** [redacted] **Cell Phone #:** (Optional)

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

	Certified?	Practicing?
OBG	Y	Y
GYN	Y	Y
DR	N	Y

Make corrections if necessary

	Certified?	Practicing?

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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

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

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Other than in Arizona, are you currently under investigation by any medical board or peer review body? ☐ Yes ☑ No
2. Other than in Arizona, since your last renewal have you had a medical license disciplined resulting in revocation, suspension, limitation, restriction, probation, voluntary surrender or cancellation during an investigation? (**see instructions on back**) ☐ Yes ☑ No
3. Since your last renewal have you had hospital privileges revoked, denied, suspended or restricted? (**see instructions**) ☐ Yes ☑ No
4. Since your last renewal, have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? (**see instructions**) ☐ Yes ☑ No
5. Since your last renewal, have you had the authority to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered or revoked by a federal or state agency? (**see instructions**) ☐ Yes ☑ No
6. Within the last 5 years, have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine? (**see instructions**) [redacted]
7. Do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication?
8. Have you consumed intoxicating beverages resulting in your present ability to exercise the judgment and skills of a medical professional, being impaired or limited
9. Have you been denied a license in another state? If yes, ☐ Yes ☑ No
   State_____ Date of Denial_____ Reason for Denial_____
10. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? ☐ Yes ☑ No
    If yes, please attach an explanation and applicable court docket. See instructions on back.
11. Since your last renewal, has a malpractice lawsuit resulted in a settlement or judgment against you? ☐ Yes ☑ No

If the answer is "yes" to any of the above questions, please provide a complete written explanation to include dates. If malpractice cases are reported, please include: a copy of the complaint and settlement agreement/judgment.

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2003 and 2004, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

Signature of Licensee (Signature stamp will not be accepted) — Date: 1/25/05

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

ARIZONA MEDICAL BOARD
2003 BIENNIAL MD LICENSE RENEWAL APPLICATION

2981

AZ MD Lic#: 18821 Edward R. Watson, MD **Renewal Fee: $450** **$800** (If postmarked after 03/10/2003)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS 6201 SW 70th St South Miami FL 33143-4718	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** 6660 S.W. 117th St Av. Miami, Fla. 33183
Phone #: (305) 667-6697 **Fax #:** (305) 667-1698 **E-Mail:**	**Phone #:** (305) 630-3363 **Fax #:** (305) 630-3364 **E-Mail:**
MAILING ADDRESS [redacted]	**MAILING ADDRESS** [redacted]
HOME ADDRESS [redacted]	**HOME ADDRESS** [redacted]
Phone #: [redacted] **Fax #:** **E-Mail:**	**Phone #:** [redacted] **Fax #:** [redacted] **E-Mail:** **Cell Phone #:** [redacted] (Optional)

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FEB - 4 2003
By

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

	Certified?	Practicing?
OBG	Y	N
DR	N	Y
GYN	N	Y

Make corrections if necessary

	Certified?	Practicing?
OBG		Y
GYN	Y	Y

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

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If the answer is "yes" to any of the above questions, please provide a complete written explanation. If malpractice cases are reported, please include: the case number, venue, plaintiff name, and attorney names/addresses/phone numbers.

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2000 and 2001, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

[signature] M.D.
Signature of Licensee (Signature stamp will not be accepted)

2/3/03
Date

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