Interstate Medical Licensure Compact
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PHYSICIAN'S CORE DATA SHEET

(*Must be the **physician's** accurate information to avoid delay or rejection*)

Full Legal Name __**Stephanie** , __**Blair** , _**Long** , __

Other names used (maiden, birth) [redacted]

Residential address [redacted]

Office address _**777 N Raymond Street** , _**Boise** , _**IDAHO** , _**83704** ,

Where do you wish to receive mail. Residential

Physician's cellular or alternative telephone numbe [redacted]

Physician's office or practice telephone number of public record _**(208) 514 - 2500**_

Date of Birt [redacted] Gender: Female

Applicants personal email address [redacted]

Email address delegated by applicant to receive correspondence ____

Social Security Number: [redacted]

Physician's National Provider Identifier Number _**1043448236**_

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Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes

Medical School __**Columbia University College of Physicians and Surgeons**__ Date of Degree Issued _**5/12/2009**_ Medical Degree Received: M.D.

Have you passed each component or step of the USMLE, or the COMLEX-USA within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes (if in question contact your SPL)? Yes

Which licensing exam did you pass? __**USMLE**_

Have you successfully completed graduate medical education approved by the ACGME or the AOA? Yes

Residency Program _**Family Medicine Residency of Idaho**__Completion Date__**6/30/2012**__

What is the specialty of the program ___**Family Medicine**_____

Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? (Board eligibility does not qualify) Yes

Name of Specialty Board Certification _**American Board of Family Medicine**_

Lifetime _**No**_ If not lifetime, Expiration Date _**6/30/2022**_

Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? No

Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? No

Have you ever had a controlled substance license or permit suspended or revoked by a state or

the United States Drug Enforcement Administration? No

Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? No

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Application for Expedited Licensure

I have read and understood the Qualifications to practice medicine in the Compact states. I attest that I am qualified and understand that pursuant to the IMLCC's rules, all fees are non-refundable. **Yes**

If you have questions please call your State of Principle License

I understand that inaccurate or missing information may be grounds for rejection of my application.

Please carefully review the Application documents before applying. **Yes**

I have reviewed the criteria to select a State of Principal License (SPL) and confirm eligibility to designate a Compact state as my SPL. **Yes**

I have a full and unrestricted license in a Compact State **Yes**

SPL **IDAHO BOARD OF MEDICINE** License # **M11169**

AND at least one of the below must APPLY (Please select all that apply)

a. Your primary residence is in the SPL (State of Principal License) Yes
b. At least 25% of your practice of medicine occurs in the SPL Yes
c. Your employer is located in the SPL Yes
d. You use the SPL as your state of residence for U.S. federal income tax purposes Yes

Please provide below information:

Residence Street addres [redacted]

Residence City State Zip [redacted]

Please describe your practice and location in the SPL selected **I work at the Family Medicine Residency of Idaho as an attending physician.**

Please be prepared to provide documentation to the designated SPL for further verification. If you have any question please contact your SPL.

You or your employer may be asked for additional documentation about your Employment.

Name of Employer **Family Medicine Residency of Idaho** Employer Contact Phone **(208) 954 - 8746**

Employer Street address **777 N Raymond Street**

Employer City State Zip **Boise**, **IDAHO**, **83704**

Please provide your Tax ID # (SS#, EIN [redacted] (must be most recent return)Please be prepared to provide documentation to the designated SPL for further verification.

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AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR AN IMLC LETTER OF QUALIFICATION AND MEDICAL LICENSES IN IMLC MEMBER STATES

I, _Stephanie_Blair_Long__ (full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof, furnished or to be furnished with respect to my application, are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as potential prosecution under appropriate federal and state laws.

I hereby apply to _**IDAHO BOARD OF MEDICINE**_ (state) as my State of Principal License ("SPL") for a Letter of Qualification ("LOQ") to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I authorize and request every person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, to furnish to the SPL any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the SPL, or any of its agents or representatives, to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact.

I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, of any and all liability of every nature and kind, arising out of an investigation made by the SPL.

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application. Additionally, I further authorize the SPL to process and release my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind, arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application, if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a LOQ, revocation, or other disciplinary sanctions of my license(s) or permit(s) to practice medicine, in one or more Compact Member States.

Applicant Signature Stephanie Long

Type Applicant's Name Stephanie Long
Applicant's NPI 1043448236
Date 12/16/2021

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Letter of Qualification

Date: 2/7/2022

Name: Stephanie Blair Long

Address: [redacted]

CityStZip [redacted]

Dear Dr.: Stephanie Blair Long

RE: Your application for IMLC Letter of Qualification

The IDAHO BOARD OF MEDICINE ("Board"), on behalf of the State of Principal Licensure ("SPL") you selected, has received and reviewed your application for a Letter of Qualification ("LOQ") for licensure through the Interstate Medical Licensure Compact ("IMLC").

Based upon the information you submitted with your application, data in the Board's files regarding your licensure by the Board, verifications of your credentials, and the results of the check of national databases, the Board has determined that you are ELIGIBLE to be licensed through the IMLC. Therefore, this notice will serve as your LOQ for licensure in IMLC Member States through the IMLC, and will remain in effect for 365 days from date of issuance, set out above.

An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license in by each.

All medical licenses issued by Member Boards through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions including, but not limited to, each Member Board's continuing medical education requirements. It is also your obligation to keep your SPL, the Member Boards which have licensed you, and the IMLC Commission informed of any changes in your contact information or qualifications and eligibility for licensure through the IMLC.

Authorized Signature from SPL Jodi C. Adcock

Type Name Jodi C. Adcock
Title of Authorized SPL Licensing Specialist
Date 2/7/2022

ARIZONA MEDICAL BOARD
MD IMLCC Supplemental Forms

1740 W. Adams St., Ste. 4000, Phoenix, AZ 85007-2664
www.azmd.gov; Email: licensingreport@azmd.gov

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

Personal Information

AZ License #: 66130

1. First Name: STEPHANIE

Middle Name: BLAIR

Last Name: LONG

Other Names Used:

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. Current Practice Name: TIA CLINIC

Address: 15051 North Kierland Blvd Ste 200 FB **City:** Scottsdale **State:** AZ **Zip:** 85254

Phone: (646) 650 5337 **Fax:**

***Practice address not required for licensure**

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

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

☐ **Same as Practice Address** ☒ **Same as Home Address**

ARIZONA MEDICAL BOARD
MD IMLCC Supplemental Forms

5. Area of Interest/ABMS Certification

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

Area of Interest	Practicing?	ABMS Certified?	Expiration Date (Or indicate if lifetime certificate)
Family Medicine	☒ Yes ☐ No	☒ Yes ☐ No	07/2022
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

6. Training Unit Attestation

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

Medical Practice Act Training and Questionnaire included as pages 7-10 of the Supplemental Forms.

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 these supplemental forms and available on the Board's website.

Full Name (print): Stephanie Blair Long **Signature:** [signature] **Date:** 02/16/2022

7. Non- Residency Attestation

Pursuant to Arizona Revised Statutes § 41-1080(A), an applicant for licensure must present documentation of citizenship or alien status prior to receiving a license from the Arizona Medical Board. An exception to this requirement exists for an applicant who meets all of the following criteria:

(a) The individual is a resident of another state.
(b) The individual holds an equivalent license in that other state and the equivalent license is of the same type being sought in this state.
(c) The individual seeks the Arizona license to comply with this state's licensing laws and not to establish residency in this state.

Initial SBL I am exempt from ARS § 41-1080(A) because all of the above criteria apply. I understand that in the event I establish residency in Arizona in the future and wish to continue to hold an Arizona Medical License, I will be required to submit proof of citizenship or alien status to the Arizona medical Board, prior to being eligible for licensure.

Full Name (Print): Stephanie Blair Long **Signature:** [signature] **Date:** 02/16/2022

Gmail

Bernita Stark <bernita.stark@azmd.gov>

Re: IMLCC License Approval

1 message

Stephanie Long [redacted] Fri, Mar 4, 2022 at 6:27 PM
To: Bernita Stark

Dear Bernita,

I hope this finds you well. Attached is a PDF of my completed forms. Please do let me know if you need anything else.

Best,
Stephanie

On Tue, Feb 8, 2022 at 4:45 PM Stephanie Long [redacted] wrote:

> Thank you, Bernita. Acknowledging receipt and I will get these back to you as soon as possible.
>
> Best,
> Stephanie
>
> On Tue, Feb 8, 2022 at 12:33 PM Bernita Stark <bernita.stark@azmd.gov> wrote:
>
> > Dr. Long,
> >
> > Attached please find your official approval letter containing your Arizona Medical License number and renewal/expiration dates.
> >
> > Included with the approval notice there are forms we need to have completed in order to ensure the correct information on your profile and to meet statutory requirements.
> >
> > **Please complete and email these back to me within the next 30 days.**
> >
> > If you have any questions please feel free to contact me.
> >
> > Please let me know if I can be of any further assistance.
> >
> > Bernita Stark
> > Senior Licensing Coordinator
> > Arizona Medical Board
> > Arizona Regulatory Board of Physician Assistants
> > bernita.stark@azmd.gov
> > PH: 480-551-2724

AZ compact license.pdf
3768K

Arizona Medical Board

1740 W Adams St, Suite 4000 • Phoenix, AZ 85007
Telephone: 480- 551-2700 • Fax: 480-551-2704
Website: www.azmd.gov • E-Mail: questions@azmd.gov

February 8, 2022

Stephanie Blair Long, M.D.
[redacted]

Dear Dr. Long:

This will acknowledge receipt of your application for licensure to practice medicine in the State of Arizona.

I have reviewed your application and determined that there are outstanding items. To complete the processing of your application, the following documentation is still required:

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

Please be advised that if your application is not fully complete within one year from this date, your application is deemed withdrawn.

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

Sincerely,
Arizona Medical Board

Arizona Medical Board
1740 W. Adams St. Ste. 4000, Phoenix, AZ 85007
Telephone: 480- 551-2700 • Fax: 480-551-2704
Website: www.azmd.gov

May 11, 2022

Stephanie Blair Long, MD
[redacted]

RE: Biennial Renewal of Arizona Medical License #66130

CME Audit - 10% Randomly Selected

Dear Dr. Long,

You are due to renew your license to practice medicine in the state of Arizona. The license renewal fee of $500.00 and renewal application is due [redacted] A late fee of $350.00 will be assessed if you do not renew your license befo **22**. Your license will expire if not renewed before **11/15/2022**.

How to renew your Compact License:
1. Go to www.imlcc.org
2. Click on Renewals at the top in the middle.
3. Enter your information.
4. You will enter Arizona for the state to renew.
5. Enter the State of Principal License
6. Your renewal fee is $500.00
7. A late fee of $350.00 will be applied if not renewed by the date referenced above.

If you are selected for CME Audit you will be notified by the Arizona Medical Board after your renewal application is submitted. It is your responsibility to ensure the information on your profile is accurate. Prior to completing your renewal application please review your physician profile found on the website www.azmd.gov. To view your profile click on “Find your MD/Resident/Temp License” - You will then be able to enter your name or enter your Arizona license number. If corrections are needed please print your profile, make corrections and email the board at licensingreport@azmd.gov
.

Controlled Substance Prescription Monitoring Program
Please Note: All licensed MDs with a DEA Registration or who intend to apply for a DEA Registration in Arizona are required to register with the Controlled Substance Prescription Monitoring Program.

If you have questions, please contact us via email at LicensingReport@azmd.gov or by phone at (480) 551-2700.

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Application for Renewal Licensure

I attest that I am qualified and eligible to Renew my license through the Compact. **Yes**

I understand that inaccurate or missing information may be grounds for rejection of my application.
Please carefully review the Renewal Application before applying. **Yes**

I understand pursuant to IMLC rules, all fees are non-refundable. **Yes**

Full Legal Name _**Stephanie**_ , _**Blair**_ , _**Long**_ , __

NPI _**1043448236**_ State of Renewal _**ARIZONA MEDICAL BOARD**_
License #_**66130**_

Renewal Cost _**$500.00**_ Late Fees __

I understand the statutes and regulations related to the Renewal of my license. I attest that I am in compliance with these rules. **Yes**

I have maintained a full and unrestricted license in my State of Principal License (primary state of LOQ) **Yes**

SPL _**IDAHO BOARD OF MEDICINE**_ License# _**M11169**_ Expiration __

Have you been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? **No**

Have you held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to "Renewal" of a license? **No**

Have you ever had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? **No**

Interstate Medical Licensure Compact
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ATTESTATION

I, _Stephanie_Blair_Long__ the undersigned, hereby attest and certify that I am the person named in this APPLICATION FOR RENEWAL OF MEDICAL LICENSE IN AN IMLC MEMBER STATE THROUGH THE IMLC ("Renewal Application") that I have submitted, that all statements I have made or shall make with respect thereto are true, and that all statements, representations, documents, forms, or copies thereof furnished or to be furnished with respect to my Renewal Application are strictly true in every aspect.

I hereby apply to _ARIZONA MEDICAL BOARD_ ("Member Board") and further authorize the Member Board to process my Renewal Application for renewal of medical licensure by the Member Board, and I hereby release, discharge, and exonerate the Member Board, the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind arising out of any disclosure to the Member Board.

I acknowledge that I have read, understand and answered all questions contained in the Renewal Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to a refusal to renew a medical license or permit, or disciplinary action against one or more medical licenses or permits I hold, as well as my being prosecuted under appropriate federal and state laws.

I understand and acknowledge that the Member Board may require submission of information in addition that provided with this Renewal Application; that I am required to comply with all of the Member Board's continuing professional development or medical education requirements; and, thatmy failure to submit such information to the Member Board, or to comply with the Member Board's continuing professional development or medical education requirements, may constitute grounds for revocation of, or other disciplinary action against, the medical license issued to me and renewed by the Member Board in response to this Renewal Application.

I hereby release, discharge, and exonerate the SPL, the Member Board, and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the SPL or the Member Board.

I will immediately notify the SPL, the Member Board, and the Commission in writing of any changes to the answers to any of the questions contained in the Renewal Application if such a change occurs at any time prior to a medical license being renewed by the Member Board.

I understand my failure to answer questions contained in the Renewal Application truthfully and completely may lead to denial of my renewal of a medical license in the Member Board, and revocation of, or other disciplinary action against, my license(s) or permit(s) to practice medicine in one or more Compact Member States.

Applicant's Signature Stephanie Long

Applicant's Name Stephanie Long
Applicant's National Provider Identifier (NPI) Number 1043448236
Date 7/12/2022

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PHYSICIAN'S CORE DATA SHEET

(*Must be the physician's accurate information to avoid delay or rejection*)

Personal Email Address [redacted]

Residential address_ [redacted]

Office address **_777 N Raymond Street_**, **_Boise_**, **_IDAHO_**, **_83704_**

Where do you wish to receive mail. Residential

Physician's cellular or alternative telephone number [redacted]

Physician's office or practice telephone number of public record **_(208) 514 - 2000_**

1. The majority of my practice is in:

- Direct Patient Care **Yes**
- Telemedicine **No**
- Teaching **No**
- Research **No**
- Other (explain) **Yes Leadership**

2. In what cities do you practice medicine?

Name	**Code (State)**
Scottsdale	AZ

3. Did you find the IMLC license process beneficial?

- Strongly Agree **No**
- Agree **Yes**
- Neutral **No**
- Disagree **No**
- Strongly Disagree **No**