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NOV 05 2014
AZ MEDICAL BOARD

ARIZONA MEDICAL BOARD
MD INITIAL AND ENDORESMENT LICENSE APPLICATION

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

Revised 9/05/2014

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

1. **First Name:** Carleyna
   Middle Name: Mariah
   Last Name: Nunes
   Other Names Used: Carleyna Mariah Dancingstar Nunes
2. **Social Security Number:** [redacted] *No dashes*
3. **Date of Birth:** [redacted]
4. **City of Birth:** [redacted] **State of Birth:** [redacted]
   OR **Country of Birth:** [redacted]

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

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.

5. **Practice/Training Name:** University of Arizona Medical Center
   Practice/Training Address: 1501 N. Campbell **City:** Tucson **State:** AZ **Zip:** 85718
   Practice Phone: 520-626-6636 **Practice Fax:** 520-626-1446

Mailing Address: 6520 N. Camino Padre Isidoro **City:** Tucson **State:** AZ **Zip:** 85718

Email: [redacted]

(required)

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

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

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

☒ **I am a U.S. Citizen or U.S. National.** (If this box is checked, please submit with your application a certified copy of your Birth Certificate or U.S. Passport.)*

☐ **I am NOT a U.S. Citizen or U.S. National.** (If this box is checked, please submit with your application a copy of your permanent resident card or Visa.)*

*See Evidence list for complete list of accepted documents available at www.azmd.gov.

7. **Please list all states or provinces in which you have applied for or have been granted a license or registration to practice medicine, including license number, date issued and current status of the license. If more than five, attach a separate listing. If a license is pending or was not issued, so state. If none, please indicate "Not Applicable."**

	State Board:	License No.:	Date Issued	License Status:
a.	Not Applicable			Not Applicable
b.				
c.				
d.				
e.				

8. **Medical School Name:** Alpert Medical School, Brown University

Medical School Location: Providence, Rhode Island **Graduation Date:** 05/27/2011

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

ECFMG No.: Certificate Date:

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

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

a. Institution: University of Arizona Medical Center City: Tucson State: AZ
Type of Program: Residency Dates of Attendance: From: 07/01/2011 To: 07/01/2015

b. Institution: City: State:
Type of Program: Dates of Attendance: From: To:

c. Institution: City: State:
Type of Program: Dates of Attendance: From: To:

d. Institution: City: State:
Type of Program: Dates of Attendance: From: To:

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

☒ United States Medical Licensing Exam (USMLE): Step 3 Date: 06/01/2012 State: Arizona

☒ State Written Examination: Date: Expected 06/29/2015 State: Arizona *The Commonwealth of Puerto Rico is not accepted.*

☐ National Board of Medical Examiners Examination (NBME): Certification Date:

☐ Federation of State Medical Boards Licensing Examination (FLEX): Date:

☐ Licentiate of the Medical Council of Canada (LMCC): Date:

☐ Special Purpose Examination (SPEX): Date: State:

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

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
Not Applicable	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

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

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

QUESTIONNAIRE

1. Have you had any application for medical licensure denied or rejected by another state or province licensing board? ☐ Yes ☒ No

2. Have you had any disciplinary or rehabilitative action taken against you by another licensing board, including other health professions? ☐ Yes ☒ No

3. Have you had any disciplinary actions, restrictions or limitations taken against you while participating in any type of training program or by any health care provider? ☐ Yes ☒ No

4. Have you ever been found in violation of a statute, rule, or regulation of any domestic or foreign governmental agency? ☐ Yes ☒ No

5. Have you been under investigation by any medical board or peer review body? ☐ Yes ☒ No

6. Have you ever had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation during an investigation, or entered into a consent agreement or stipulation? ☐ Yes ☒ No

7. Have you had hospital privileges revoked, denied, suspended, or restricted? ☐ Yes ☒ No

8. Have you been named as a defendant in a malpractice matter currently pending or that resulted in a settlement or judgment against you? If so, provide an explanation and a copy of the complaint and either the agreed terms of settlement or the judgment. The verification must contain the name and address of each defendant, the name and address of each plaintiff, the date and location of the occurrence which created the claim and a statement specifying the nature of the occurrence resulting in the medical malpractice action. ☐ Yes ☒ No

9. Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, sanction, or removal from practice, imposed by an agency of the federal or state government? ☐ Yes ☒ No

10. Have you had the authority to describe, dispense or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency? ☐ Yes ☒ No

11. Have you been found guilty or entered into a plea of no contest to a felony, misdemeanor involving moral turpitude in any state? (See list of explanations on web site at www.azmd.gov/Misdemeanors/Misdem.aspx) ☐ Yes ☒ No

12. Do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication? [redacted]

NOTE: In the event that the response to any of the questions above is "Yes," you must file an explanation.

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

CONFIDENTIAL QUESTIONS

1. 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? [redacted]

2. Have you consumed intoxicating beverages resulting in your ability being impaired or limited to exercise the judgment and skills of a medical professional?

NOTE: In the event that the response to any of the questions above is "Yes," you must file an explanation.

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

First Name: Carleyna **Last Name:** Nunes

SUPPLEMENTAL FORM

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

First Name: Carleyna **Last Name:** Nunes

HOSPITAL AFFILIATION

☒ **Check here if you have not held hospital affiliations within the past 5 years**

a. Hospital/Clinic Name: From: To:
Address: City: State: Zip:
Position Held:

b. Hospital/Clinic Name: From: To:
Address: City: State: Zip:
Position Held:

c. Hospital/Clinic Name: From: To:
Address: City: State: Zip:
Position Held:

HOSPITAL EMPLOYMENT

☐ **Check here if you have been self employed for the past 5 years** ☐ **Check here if you have not been employed for the past 5 years**

Not Applicable as have been in Post graduate Training

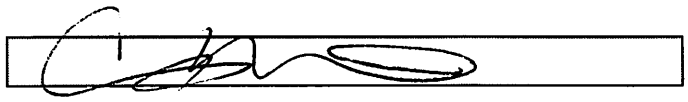
a. Employer Name: From: To:
Address: City: State: Zip:

b. Employer Name: From: To:
Address: City: State: Zip:

c. Employer Name: From: To:
Address: City: State: Zip:

ATTESTATION:

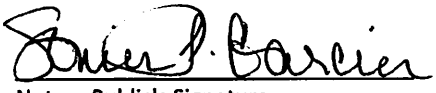
I attest that all of the information contained in the application and accompanying evidence or other credentials submitted are true. I attest the credentials submitted with the application were procured without fraud or misrepresentation or any mistake of which I am aware, and that I am the lawful holder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

Signature of Applicant:  Date: 10/29/14

Notarization

Before me, Sonia Garcia on this day personally appeared Carleyna Nunes known to me (or proved to me on the oath of _____ or through (description of identity card or other document)) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this 29th day of October, 2014.



Notary Public's Signature

(Personalized Seal)

First Name: Carleyna **Last Name:** Nunes

SONIA P GARCIA
Notary Public - Arizona
Pima County
My Comm. Expires Aug 24, 2016

Application Instructions

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

1. All applicants must submit a certified copy of a passport or birth certificate (a notarized copy is not a certified copy)
2. *Proof of immigration status as required in the Evidence list*
   (available online at *http://www.azmd.gov/PhysicianCenterNewAZLicense.aspx*)
3. Certified evidence of legal name change if name is different from that shown on documents submitted with the application.
4. Citizenship Status form. The Citizenship status form applies to both U.S.A. Citizens and Non-Citizens alike. (provided with the application)
5. A payment of $500 for processing your application. Should your application be approved you will be charged an additional fee which is a prorated licensing fee **of up to an additional $500** to cover your license through the time of renewal.
6. Medical Practice Act Training and Questionnaire form (provided with application)

Application Checklist

The APPLICANT must forward the following enclosed forms to the appropriate entity for completion. (If applicable)
(Once completed by the entity, these forms are to be sent directly to the AMB.)

- [x] Medical College Certification
- [x] Postgraduate Training Certification
- [ ] ECFMG Certification, if applicable
- [x] Federation of State Medical Boards Disciplinary Search
- [x] American Medical Association Physician Profile
- [ ] Verification of American Board or Medical Specialty Certification, if applicable
- [x] Examination Results
  USMLE, FLEX, SPEX, NBME or any State exam
- [ ] Licentiate of the Medical Council of Canada (LMCC)
- [ ] Verification of Licensure from every state in which you have ever held a medical license or registration
- [x] Verification of all medical employment for the past five years. This must be submitted by the verifying entity on its official letterhead.
- [ ] Verification of Hospital Affiliations for the past five years. This must be submitted by the verifying entity on its official letterhead.
- [ ] Fingerprint Submission

Clinical Instructor Certification form can be found online at www.AZMD.gov. This form is only needed to meet the requirements of A.R.S.§32-1423

NOTE: Arizona law requires an applicant who has been charged with a felony or a misdemeanor involving conduct that may affect patient safety after submitting the application to notify the Board within 10 days after the charge is filed. A.R.S. §32-3208. For a list of reportable misdemeanors, see the website under Physician Center - Reportable Misdemeanors. All felonies are reportable.

In addition to your e-mail address provided on page one of this application please indicate if you would like to designate/ authorize ONE other individual beside yourself to receive status updates on your application:

Name Carson Nunes Phone# [redacted] E-mail [redacted]

First Name: Carleyna **Last Name:** Nunes

Directions:

Please read the case studies and general questions along with the correct responses to each of the questions posed. This training module is designed to increase your awareness of the statutes and rules that govern the practice of medicine in Arizona. When you have read through the material, please sign the attestation indicating you have done so and that you are aware that the Medical Practice Act contains the statutory obligations you must meet when you practice medicine in Arizona. Please be advised that you may access the Medical Practice Act and the corresponding rules on the Board's website: www.azmd.gov

Medical Practice Act Training & Questionnaire

CASE STUDIES (Multiple Choice)

This section illustrates common violations of the MPA by using case scenarios. Each scenario is followed by a multiple-choice question and the answer.

1. Sexual Conduct

Scenario: You and a patient develop mutual feelings for each other during the course of treatment. You begin dating the patient and mutually agree to begin a sexual relationship. Should you continue to medically treat the patient?

A. Yes. The treatment began before a sexual relationship was developed. Therefore, it is appropriate to continue treating the patient as you were before.
B. Yes. You can maintain a boundary between your personal feelings for the patient and your professional practice.
C. No. The physician-patient relationship must be terminated six months before engaging in sexual conduct.
D. No. A physician should never establish a sexual relationship with a current or former patient.

Answer: C. No. The physician-patient relationship must be terminated six months before engaging in sexual conduct.

A.R.S. 32-1401(27)(z) states that it is unprofessional conduct to engage in sexual conduct with a current patient or with a former patient within six months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating or engagement relationship with the licensee.

2. Controlled Substances

Scenario: You are experiencing back pain after a weekend spent moving into a new home. You know the appropriate dose of Oxycodone to relieve your pain. Instead of requesting an appointment with your primary care physician you call in a prescription to the pharmacy for yourself. Are your actions appropriate?

A. No. Regardless of how seemingly obvious the cause of the pain and type of controlled substance needed, it is never appropriate for a physician to self-prescribe a controlled substance.
B. No. There are alternative over the counter drugs that can provide the same effect.
C. Yes. You had the same back pain in the past and you were previously prescribed the same medication.
D. Yes. You are a licensed physician. You know exactly what medications you need to feel better.

Answer: A. No. Regardless of how seemingly obvious the illness and type of controlled substance needed, it is never appropriate for a physician to self-prescribe a controlled substance.

A.R.S. 32-1401(27)(g) states that it is unprofessional conduct to use controlled substances except if prescribed by another physician for use during a prescribed course of treatment.

3. Professional Connection

Scenario: Your friend "Bob" wants to open a laser clinic and perform varicose vein removal. Bob is not a licensed doctor in Arizona, but he holds a medical license in New Mexico. You are confident that Bob has the education and training to safely perform varicose vein removal, even though it is considered to be the practice of medicine in Arizona. You decide to help Bob out and let him operate his laser clinic under your name. Is this appropriate?

A. Yes. Even though Bob is not licensed in Arizona, he is a doctor and you know he will do a good job.
B. Yes. The clinic operates under your name and you know Bob will call you with any problems.
C. No. Varicose vein removal is considered to be the practice of medicine and Bob is not licensed to practice medicine in Arizona.
D. No. The state where Bob is licensed may have different regulations for operating a laser clinic than Arizona and you can't be sure if Bob's clinic will meet Arizona regulations.

Answer: C. No. Varicose vein removal is considered to be the practice of medicine and Bob is not licensed to perform medicine in Arizona.

A.R.S. 32-1401(27)(cc) states that it is unprofessional conduct to maintain a professional connection with or lend one's name to enhance or continue the activities of an illegal practitioner of medicine.

4. False or Fraudulent Statements

Scenario: You are applying for privileges at a hospital and one of the questions asked of you is whether your license has ever been revoked or suspended. Knowing that the hospital will likely deny you privileges if you answer affirmatively, you opt to knowingly withhold the fact that your license was previously suspended over 15 years ago. Are your actions justified?

A. Yes. Because your suspension was so long ago, it is likely the hospital will never find out about it.
B. Yes. Ever since you got your license back, you have been a model physician and you have obeyed all laws.
C. No. The hospital will eventually find out and report you to the Board, resulting in more trouble.
D. No. It is never okay to make a false statement when applying for hospital privileges.

Answer: D. No. It is never okay to make a false statement when applying for hospital privileges.

A.R.S. 32-1401(27)(t) states that it is unprofessional conduct to knowingly make any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution.

5. Financial Interest

Scenario: You are a pain specialist and many of the patients you see benefit from a combination of pain medication and other forms of therapy, such as physical therapy. In addition to your pain clinic, you are also part owner of an outpatient physical therapy clinic. If you prescribe physical therapy at the clinic where you are part owner, should you inform the patients that you have a direct financial interest in the clinic?

A. No. Your patients will receive good care at the physical therapy clinic and do not need to know.
B. No. The amount of money you receive from your ownership interest in the clinic is not enough to require you to inform your patients.
C. Yes. You should inform patients of your financial interest and let them know they can receive therapy elsewhere.
D. Yes. You should inform patients of your financial interest, but stress that they will receive the best therapy at your clinic.

Answer: C. Yes. You should inform patients of your financial interest and let them know they can receive therapy elsewhere.

A.R.S. 32-1401(27)(ff) states that it is unprofessional conduct to knowingly fail to disclose to a patient on a form that is prescribed by the board and that is dated and signed by the patient or guardian acknowledging that the patient or guardian has read and understands that the doctor has a direct financial interest in a separate diagnostic or treatment agency or in non-routine goods or services that the patient is being prescribed and if the prescribed treatment, goods or services are available on a competitive basis. This subdivision does not apply to a referral by one doctor of medicine to another doctor of medicine within a group of doctors of medicine practicing together. A "Notice To Patients" form can be downloaded off the Board's website.

6. GENERAL QUESTIONS (True or False)

1. It is acceptable practice for me to prescribe controlled substances to my spouse and family.

   (False: A.R.S. 32-1401(27)(h) states that it is unprofessional conduct to prescribe controlled substances to members of the physician's immediate family.)

2. If a patient requests her medical records, I can provide a copy of the records, not the original.

   (True: A.R.S. 12-2297 states that a health care provider shall retain the original or copies of the medical records.)

3. If I don't provide the Arizona Medical Board with an office address, the Board can give the public my home address.

   (True: A.R.S. 32-3801 states that a professional's residential address and residential telephone number or numbers maintained by the Board are not available to the public unless they are the only address and numbers of record.)

4. I can ask my medical assistant to provide injections to my patients while I am out of the office.

   (False: Medical assistants may only administer injections under the direct supervision of a physician, physician assistant or nurse practitioner. A.R.S. 32-1456. Direct supervision is defined in A.R.S. 32-1401 as being in the same room or office suite as the medical assistant.)

5. I can earn one credit hour of continuing medical education by reading scientific journals and books.

   (True: A credit hour may be earned for activities that provide an understanding of current developments, skills, procedures, or treatments related to the practice of allopathic medicine, including reading scientific journals and books. R4-16-101(B)(8).)

6. If the Board issues me a non-disciplinary advisory letter, I can file a written response with the Board within thirty days of receiving the advisory letter.

   (True: An advisory letter cannot be appealed, but physicians do have the right to file a written response. The written response is considered to be part of the public record and will be included with any public records requested on a physician.)

7. I am required to report to the Board any information that appears to show that a doctor of medicine is or may be medically incompetent, is or may be guilty of unprofessional conduct, or is or may be physically unable safely to engage in the practice of medicine.

   (True: A doctor of medicine is required to report to the Board any information that appears to show that a doctor of medicine is or may be medically incompetent, is or may be guilty of unprofessional conduct, or is or may be physically unable safely to engage in the practice of medicine. A.R.S. 32-1451(A).)

8. I can charge a patient for medical records before I agree to send them to another physician.

   (False: A health care provider may not charge for medical records provided to another health care provider for the purpose of providing continuing care to the patient. A.R.S. 12-2295.)

9. If a patient asks for his medical records to be transferred to another provider, I am no longer responsible for retaining the records according to state retention laws.

   (False: The law does not provide an exception to the medical record retention requirements. A.R.S. 12-2297.)

10. The Arizona Medical Board can charge me $100 for failing to provide a current office and home address within 30 days of the date of the address change.

    (True: The Arizona Medical Board may assess the costs incurred by the Board in locating a licensee and in addition a penalty of not to exceed one hundred dollars. A.R.S. 32-1435(B).)

11. If I self report to the Board my substance abuse problem I may be eligible to participate confidentially in the Arizona Medical Board's treatment and rehabilitation program.

(True: The Arizona Medical Board has a program for the treatment and rehabilitation of physicians who are impaired by alcohol or drug abuse. Physicians meeting the program requirements may participate confidentially. A.R.S. 32-1452.)

12. I can prescribe to patients who fill out an on-line health questionnaire, even if I have never met them.

(False: It is unprofessional conduct to prescribe, dispense or furnish a prescription or prescription-only device to a person without first conducting a physical examination or previously establishing a doctor-patient relationship. A.R.S. 32-1401(27)(ss).)

13. If I don't receive a reminder from the Arizona Medical Board to renew my license on time, I am not responsible for a late fee or non-renewal.

(False: It is your responsibility to ensure your license is renewed on time.)

14. If my patient refuses to notify her spouse that she is HIV positive, I can report the name of her spouse to the Arizona Department of Health Services.

(True: A.R.S. 32-1457 states that it is not an act of unprofessional conduct for a doctor to report to the department of health services the name of a patient's spouse or sex partner or a person with whom the patient has shared hypodermic needles or syringes if the doctor knows that the patient has contacted or tests positive for the human immunodeficiency virus and that the patient has not or will not notify these people and refer them to testing.)

15. The Arizona Medical Board will only investigate a malpractice complaint if there was a settlement over one million dollars.

(False: On receipt of a malpractice report and a copy of a malpractice complaint as provided in section 12-570, the health profession regulatory board shall initiate an investigation into the matter to determine if the licensee is in violation of the statutes or rules governing licensure. A.R.S. 32-3203.)

Attestation: (Please check one)

I hereby attest that I have read the training material provided in accordance with:

☒ 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.

☐ Renewal Applications - A.R.S §32-1430(C): The licensee shall submit proof with the renewal form of having completed a training unit as prescribed by the board relating to the requirements of this chapter and board rules

I am aware that I am responsible for knowing and adhering to the laws governing the practice of medicine in Arizona.

Full Name (Print): Carleyna Nunes **Signature & Date:** 10/29/14

License number: R726002
-Postgraduate Training License #

Gmail by Google

Carleyna Nunes <carleyna.nunes@gmail.com>

Transcript Order #14955381: Consent Form Received

1 message

Do Not Reply <donotreply@studentclearinghouse.org> Wed, Oct 29, 2014 at 12:36 PM
To: [redacted]

****
This e-mail was sent from a notification-only address that cannot accept incoming e-mail. Please DO NOT reply to this message.
****

This is to confirm that we have received the signed consent form for your transcript order. We will now submit your transcript order to your educational institution for processing. You can track your transcript order by entering the order number on this email and the email address you used to place the order on the following web page: https://www.studentclearinghouse.org/TO.asp?FICECode=00340100

YOUR ORDER DATE: 10/29/2014 3:35 PM ET
YOUR SCHOOL: Brown University (003401-00)
CONSENT FORM RECEIVED: 10/29/2014 3:36 PM ET

RECIPIENT: ARIZONA MEDICAL BOARD
DELIVERY METHOD: Electronic PDF - $1.75
IMPORTANT: Shortly after your request is fully processed and sent by the Office of the Registrar at Brown University, the intended recipient will be sent a link to a secure internet site via e-mail to the address YOU provide where they may retrieve the document. While the National Student Clearinghouse will guarantee that your recipient, via the e-mail address YOU provide at time of order, is notified that the electronic transcript is ready for retrieval, neither the NSC nor Brown University can be responsible for whether or not the recipient retrieves and/or accepts the electronic version of the transcript. Accordingly, NO REFUNDS are issued once the transcript request is processed and sent; therefore, we suggest that you contact your recipient and verify that they will accept the transcript via this method.

TOTAL FEES FOR THIS ORDER: $8.00
Your credit card will not be charged until the transcript(s) are sent.

****

Questions? Go to http://help.studentclearinghouse.org
and select Transcript Ordering Help.

National Student Clearinghouse
www.studentclearinghouse.org

****

Gmail by Google

Carleyna Nunes <carleyna.nunes@gmail.com>

MD verification letter

2 messages

Carleyna Nunes [redacted] Wed, Oct 29, 2014 at 1:06 PM
To: Janet_Prata@brown.edu

Hi Ms. Prata,

I graduated from Brown Med in 2011 and am now applying for an Arizona medical license and need an MD verification letter sent to the Arizona Medical Board. I will fax you the signed authroization. Please send the letter to the address below.

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

Thank you so much,

Carleyna Nunes

Prata, Janet <janet_prata@brown.edu> Fri, Oct 31, 2014 at 10:39 AM
To: [redacted]

Hi Carleyna,

I'm mailing your MD verification letter out today, and so you are all set. If you need anything else, please let me know!

Have a good weekend,

Janet
[Quoted text hidden]
–
Janet Prata
Credentialing and Verification
Alpert Medical School
Medical School Administration
222 Richmond Street, Box G-M118A
Providence, RI 02912
PHONE 401-863-3986
FAX 401-863-5096

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

☒ United States Medical Licensing Exam (USMLE): Step 3 Date: 6/1/2012 State: Arizona

☒ State Written Examination: Date: Expected 6/29/2015 State: Arizona *The Commonwealth of Puerto Rico is not accepted.*

☐ National Board of Medical Examiners Examination (NBME): Certification Date:

☐ Federation of State Medical Boards Licensing Examination (FLEX): Date:

☐ Licentiate of the Medical Council of Canada (LMCC): Date:

☐ Special Purpose Examination (SPEX): Date: State:

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

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

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

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

Arizona Medical Board
9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov • E-Mail: questions@azmd.gov

RECEIVED
DEC 02 2014
ARIZONA
MEDICAL BOARD

ATTESTATION AND CONSENT

I, Carleyna Nunes hereby affirm that I have not failed to disclose any criminal convictions in any other state or country. I understand and consent that my license may be subject to further review and processing by the Arizona Medical Board upon receipt of the fingerprint-based federal criminal history information and I agree to cooperate fully with any additional requests for information or documents arising therefrom. I agree that if I have failed to disclose any convictions that this may result in revocation or suspension of my license to practice medicine in Arizona.

I declare the foregoing to be true and correct.

EXECUTED THIS 1 DAY OF December, 2014.

_____ (Signature)

Carleyna Nunes (Print Name)

Notarization:

STATE OF Arizona)
) ss.
County of Pima)

Subscribed, sworn to and acknowledged before me by Carleyna Nunes this 1st day of December, 2014

_____
(Notary Public)

SONIA P. GARCIA
Notary Public - Arizona
Pima County
My Comm. Expires Aug 24, 2016

My commission expires on:
August 24, 2016

Arizona Medical Board

9545 E. Doubletree Ranch Road, Scottsdale AZ 85258 • website: www.azmd.gov
Phone (480) 551-2700 • Toll Free (877) 255-2212

November 6, 2014

Carleyna Nunes, MD
[redacted]

Dear Dr. Nunes:

This will acknowledge receipt of your application for licensure to practice medicine in the State of Arizona. I have reviewed your application. To complete the processing of your application, the following documentation is still required:

1) **Please complete application page 3, question 11 (attached). This will be the specialty listed on your public profile.**

2) **Submit a full set of fingerprints to the board for the purpose of obtaining a state and federal criminal records check.** Packet will be sent to the mailing address as shown above. **Please follow the directions exactly to avoid any delay in processing your application.**

3) **Medical College Certification**

4) **12 months ACGME Approved Postgraduate Training Verification**

5) **American Medical Association Physician Profile (available online at www.ama-assn.org)**

*Note: Upon further review, additional information may be requested.

All documents must come directly from the source excluding Birth Certificate, Passport/Legal Evidence, Application pages, Malpractice documentation, or information specifically requested to be provided by the applicant.

Although not needed for basic license requirements, if you would like additional post graduate training years to be listed on the Board's website, verification must be submitted directly from the source to the Board. Please have your ABMS Certification Verification sent from the primary source (specialty board) to the Arizona Medical Board.

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

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

Should you wish to appeal any item in this deficiency letter, you must submit your request in writing to the Board within 30 days from the date of this notice.

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

Sincerely,

Arizona Medical Board

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

☒ United States Medical Licensing Exam (USMLE): Step 3 Date: 06/01/2013 State: Arizona

☒ State Written Examination: Date: Expected 06/29/2015 State: Arizona *The Commonwealth of Puerto Rico is not accepted.*

☐ National Board of Medical Examiners Examination (NBME): Certification Date:

☐ Federation of State Medical Boards Licensing Examination (FLEX): Date:

☐ Licentiate of the Medical Council of Canada (LMCC): Date:

☐ Special Purpose Examination (SPEX): Date: State:

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

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
Not Applicable	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

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

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

Arizona Medical Board

9545 E. Doubletree Ranch Road, Scottsdale AZ 85258 • website: www.azmd.gov
Phone (480) 551-2700 • Toll Free (877) 255-2212 • Fax (480) 551-2707

Dear Applicant,

On September 2, 2014, A.R.S. § 32-1422 (12) became effective which requires that each applicant for initial licensure submit fingerprints to enable the Board to obtain a criminal background check as a basic requirement for licensure.

In order for the Board to continue to process your application, you will need to sign and return the enclosed Attestation and Consent which affirms your understanding that failure to disclose convictions may result in revocation or suspension of your license. Once properly executed, please **mail** the original notarized document to us at:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Upon receipt of the signed and notarized Attestation and Consent, the Board will then continue with the application process and may issue a license subject to additional review and processing once the Board obtains a criminal history report from the FBI. You will be notified within 15 days of receipt of the FBI report whether additional processing is required. If undisclosed criminal history is identified at that time, your license application will undergo further review, an investigation will be commenced and you will be provided an opportunity to respond.

Very truly yours,

Patricia E. McSorley

Patricia E. McSorley
Acting Interim Executive Director

Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov • E-Mail: questions@azmd.gov

ATTESTATION AND CONSENT

I, _____ hereby affirm that I have not failed to disclose any criminal convictions in any other state or country. I understand and consent that my license may be subject to further review and processing by the Arizona Medical Board upon receipt of the fingerprint-based federal criminal history information and I agree to cooperate fully with any additional requests for information or documents arising therefrom. I agree that if I have failed to disclose any convictions that this may result in revocation or suspension of my license to practice medicine in Arizona.

I declare the foregoing to be true and correct.

EXECUTED THIS ___ DAY OF _____, 20__.

_____(Signature)

_____(Print Name)

Notarization:

STATE OF _____)
) ss.
County of _____)

Subscribed, sworn to and acknowledged before me by _____ this __ day of _____, 20__

_____
(Notary Public)

My commission expires on:

ARIZONA MEDICAL BOARD
POSTGRADUATE TRAINING VERIFICATION FORM

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

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Signature: _____ **Date:** _____

Applicant: Do not fill in below this line.

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

PG Year: _____ **Department/Specialty:** _____

☐ Internship
☐ Residency
☐ Fellowship

From: _____ To: _____ (mm/dd/yy)

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

PG Year: _____ **Department/Specialty:** _____

☐ Internship
☐ Residency
☐ Fellowship

From: _____ To: _____ (mm/dd/yy)

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

PG Year: _____ **Department/Specialty:** _____

☐ Internship
☐ Residency
☐ Fellowship

From: _____ To: _____ (mm/dd/yy)

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

Affix Training Program Seal Here

1. This program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Examination Education (ACGME), or the Royal College of Physicians and Surgeons of Canada: ☐ **Yes** ☐ **No**

2. Did this individual ever take a leave of absence or break from training or request a transfer? ☐ **Yes** ☐ **No** (If yes, please attach an explanation)

3. Was this individual disciplined and/or placed under investigation or probation? ☐ **Yes** ☐ **No** (If yes, please attach an explanation)

Institution Name: _____ Name/Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Signature: _____

Date: _____ (mm/dd/yy)

BROWN
Alpert Medical School

Medical School Administration

October 31, 2014

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

To Whom It May Concern:

Subject: Carleyna Nunes, MD

This letter is to certify that Carleyna Nunes enrolled at The Warren Alpert Medical School of Brown University on August 20, 2007, and received her MD degree on May 29, 2011.

If you require any additional information, you can contact me at 401-863-5077.

Sincerely,

Kathleen Chien
Director, Medical School Administration
& REGISTRAR

BROWN
Alpert Medical School

Brown University
Medical School Administration
Box G-M1
Providence, RI 02912

PRESORTED
FIRST CLASS

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Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258

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THE UNIVERSITY OF ARIZONA
Arizona Health Sciences Center

College of Medicine
Obstetrics & Gynecology

1501 North Campbell Avenue
P.O. Box 245078
Tucson, AZ 85724-5078
Tel: 520-626-6636
Fax: 520-626-2514
www.obgyn.arizona.edu

November 11, 2014

RE: Carleyna Nunes, M.D.

To Whom It May Concern,

This letter is to certify that Carleyna Nunes, M.D. is currently an OB/GYN Resident in the Department of Obstetrics and Gynecology, University of Arizona Health Sciences Center, Tucson, Arizona and employed from July 1, 2011 through June 30, 2015. Please feel free to call my office at 520-626-6636 if you should have any additional questions or concerns.

Sincerely,

Sonia Garcia
Program Coordinator, Senior
University of Arizona
Department of Obstetrics and Gynecology

ARIZONA MEDICAL BOARD
MEDICAL EMPLOYMENT VERIFICATION REQUEST

Note: Verification is required from the employer where the applicant has been employed during the five years preceding the application.

I, Carleyna Nunes, request that verification of my medical employment be submitted on the **letterhead** of the **verifying Employer** directly to the Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258 or email: licensingreport@azmd.gov

Applicant Signature: [signature] Date: 10/29/14

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NOV 13 2014
ARIZONA
MEDICAL BOARD

THE UNIVERSITY OF ARIZONA
Arizona Health Sciences Center

College of Medicine
Obstetrics & Gynecology
PO Box 245078
Tucson AZ 85724-5078

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

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ARIZONA MEDICAL BOARD
POSTGRADUATE TRAINING VERIFICATION FORM

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

First Name: Carleyna **Middle Name:** Marie h **Last Name:** Nunes

Signature: [signature] **Date:** 10/29/2014

Applicant: Do not fill in below this line.

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

PG Year: 4 **Department/Specialty:** OB/GYN

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NOV 13 2014
ARIZONA MEDICAL BOARD

- [X] Internship
- [X] Residency
- [ ] Fellowship

From: 07/1/2011 To: 06/30/15 (mm/dd/yy)

Successfully Completed? ☐ Yes ☐ No ☒ In Progress

Has successfully completed 1st, 2nd and 3rd year.

PG Year: [ ] **Department/Specialty:** [ ]

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

From: [ ] To: [ ] (mm/dd/yy)

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

PG Year: [ ] **Department/Specialty:** [ ]

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

From: [ ] To: [ ] (mm/dd/yy)

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

Affix Training Program Seal Here

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

Institution Name: University of Arizona **Name/Title:** Amy Mitchell, MD Program Director

Address: 1501 N. Campbell, Box 245078 **City:** Tucson **State:** AZ **Zip:** 85724

Phone: 520-626-6634 **Fax:** 520-626-1446 **Signature:** [signature]

Date: 10/30/14 (mm/dd/yy)

From:	Sonia Garcia
To:	Bernita Stark
Subject:	Postgraduate Verification for Dr. Carleyna Nunes
Date:	Wednesday, November 19, 2014 12:54:45 PM
Attachments:	image001.emz image002.png oledata.mso Scan001.pdf

---

Hello Bernita,

I am attached the postgraduate verification form which was not properly completed for Dr. Carleyna Nunes. Please let me know if you have any questions or need anything else.

Thank you,
Sonia

Sonia P. Garcia
Program Coordinator, Senior
University of Arizona
Obstetrics & Gynecology
1501 N. Campbell Ave., Box 245078
Tucson, AZ 85724
Phone: 520-626-6636
Fax: 520-626-1446
E-mail: soniag@email.arizona.edu

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

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

Date : 10/29/2014

Recipient:

Arizona Medical Board
ATTN: Patricia E. McSorley, Acting Int Exe Dir
9545 E Doubletree Ranch Road
Scottsdale, AZ 85258

Examinee: Nunes, Carleyna Mariah
Alt Name(s):

Examinee ID#: 5-230-674-3
Date of Birth: [redacted]

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

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	04/25/2009	Pass	224	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	10/26/2010	Pass	252	(189)	

Clinical Skills (CS)*

	Test Date	Pass/Fail	Total	MP	Comments
	11/02/2010	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
ARIZONA	06/01/2012	Pass	227	(190)	

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

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

Examinee: Nunes, Carleyna Mariah

Examinee ID#: 5-230-674-3
Date of Birth: [redacted]

INTERPRETATION OF RESULTS

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

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

STEP 2 CLINICAL SKILLS (CS)

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

ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

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

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note. 4/2013

50034

ARIZONA MEDICAL BOARD

Verification of Submission of Certified Documents

☒ **The attached document is an acceptable certified copy and was received via;**

☒ mail ☐ email ☐ fax ☐ hand-delivery

☒ Birth certificate (USA or foreign)

☐ Passport (USA or foreign)

☐ Certified copy of medical school diploma *

☐ Certified copy of post graduate training certificate *

☐* A water mark seal, or colored seal was affixed to the original certified copy of the medical school diploma or post graduate training certificate with a statement from the program or medical school that they certify the diploma or certificate is a true copy of the original.

I Mary Dunavant employee of the Arizona Medical board certify that I made a copy of the original document (attached)

Mary Dunavant 11/5/14

Board staff signature Date

☐ **The attached document,**

☐ birth certificate (USA or foreign), ☐ passport (USA or foreign),
☐ medical school diploma ☐ post graduate training certificate

is NOT a certified copy for the following reason(s);

☐ Notarized copy

☐ birth certificate or passport was not received from Office of Vital Statistics or The Department of State, nor the original document submitted to the board.

☐ Unable to determine authenticity, does not appear to be an original copy.

☐ Other _____

☐ A seal is not affixed to copy of diploma or post graduate training certificate.

☐ A statement from the school or program is not included certifying that the document is a true copy of the original diploma or post graduate certificate.

Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2707
Website: www.azmd.gov

January 29, 2015

Carleyna Mariah Dancing Star Nunes, M.D.
6520 N. Camino Padre Isidoro
Tucson, AZ 85718

Dear Dr. Nunes,

The Arizona Medical Board is pleased to inform you that your application for licensure has been approved. Your license number will be **50034.** Your license will be activated upon receipt of the required license issuance fee of **$83.33. The license issuance fee is prorated based on birth year and month and is in addition to the $500 application processing fee submitted with your license application.** Your license renewal date will be [redacted] Thereafter, your license renewal fee is $500 every two years on your birthday.

This licensing fee can be paid by check or credit card. Please complete information below, if paying by credit card, and return to the Arizona Medical Board by fax or mail. If paying by check, please include your license number on the check and return your payment to the Arizona Medical Board at the above address.

The license issuance fee must be received within 35 days from the date of this letter or your application will be withdrawn, and you will need to reapply.

ARIZONA MEDICAL BOARD PAYMENT CARD AUTHORIZATION

Payment for: Carleyna Mariah Dancing Star Nunes, MD License #50034

Initial License Fee: $83.33

[redacted]

Arizona Medical Board
9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514

LICENSE/RENEWAL CUSTOMER SATISFACTION SURVEY

We would like to know how the License/Renewal Center of the Arizona Medical Board has assisted you during your license/renewal process. Your feedback will help us determine how to better assist other physicians. All survey responses will remain confidential. Please return this survey within two weeks by mail or fax at (480) 551-2707.

Please check the appropriate box:	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Applicable
The staff was professional	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐
The staff was courteous	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐
The staff provided accurate responses	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐
The license/renewal application directions were clear and concise	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐
The license was timely issued	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐

Please include any additional comments you have regarding the License/Renewal staff and/or the service you received. We are particularly interested in your suggestions if you answered “disagree” or “strongly disagree” above.

_____

_____

_____

AMB Physician Renewal Confirmation (Step 8 of 11) 3/16/2021

Dr. Carleyna Mariah Dancing Star Nunes

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) Test Test Test

[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		

Specialty 2

Specialty 3

Specialty 4

Practice Address

Chi St Luke's Hospital
17200 Saint Lukes Way
The Woodlands TX, 77384
Phone:
Fax

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]

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

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AMB Physician Renewal Confirmation (Step 8 of 11) 3/23/2019

Dr. Carleyna Mariah Dancing Star Nunes

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		
Specialty 2					
Specialty 3					
Specialty 4					

Practice Address

Capital Women's Care
6355 Walker Lane Suite 508
Alexandria AZ, 22310
Phone: (703) 971-7633
Fax: (703) 971-7633

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]

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

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AMB Physician Renewal Confirmation (Step 8 of 11) 4/1/2017

Dr. Carleyna Mariah Dancing Star Nunes

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		
Specialty 2					
Specialty 3					
Specialty 4					

Practice Address

Capital Women's Care
6355 Walker Lane Suite 508
Alexandria AZ, 22310
Phone: (703) 971-7633
Fax: (703) 971-7633

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

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Capital Women's Care
6355 Walker Lane Suite 508
Alexandria VA, 22310

[redacted]

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By agreeing with this data, you are signing this registration form and certifying under pentalty 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

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AMB Physician Renewal Confirmation (Step 8 of 11) 5/11/2015

Dr. Carleyna Mariah Dancing Star Nunes

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 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 .

[redacted]

10) Since 2009, have you failed the special purpose licensing examination (SPEX)?

No

Physical/Mental Health and Substance Abuse Questions

In the event you answer YES to any of the below questions, 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 physician assistantâ€™s impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with a compliance reports from the state monitoring programs

FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.

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

[redacted]

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]

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		
Specialty 2					
Specialty 3					
Specialty 4					

Practice Address

University of Arizona
Graduate Medical Education 1501 N Campbell Ave PO Box 245085
Tucson AZ, 85724
Phone (520) 626 6691
Fax:

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

6520 N. Camino Padre Isidoro
Tucson AZ, 85718
[redacted]

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.

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· 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

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