Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 W. Adams Street, Suite 2410, Phoenix, Arizona, 85007
Ph : 480-657-7703 | www.azdo.gov | questions@azdo.gov

INITIAL LICENSE APPLICATION

APPLICATION FEE: $400

THIS AREA FOR OFFICIAL USE ONLY

008014

APPROVED
JUN 28 2019

RECEIVED
AND PAID
MAR 18 2019
#Auth 2940 $400.00 MO
AZ OSTEOPATHIC BOARD
051847

FP packet + email sent 3.18.19

Download the license application instructions from www.azdo.gov and follow them carefully to avoid delays.

FAXED APPLICATIONS WILL NOT BE ACCEPTED. Answer all questions. Answer "none" or "N/A" if that is the correct response. If you fail to complete a question, your application will be considered deficient and the processing of your application will be delayed.

In accordance with Arizona Revised Statutes § 32-1822, you may be required to submit additional information, be evaluated for fitness to practice or appear before the Board for a personal interview in addition to submitting this application and requested documentation.

In accordance with A.R.S. § 41-1030 The Board is required to notify you of the following:

B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.
D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.
E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.
F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

Submitting this application does not authorize you to practice medicine or surgery in the State of Arizona.

SECTION 1: APPLICANT IDENTIFICATION AND CONTACT INFORMATION – REQUIRED

Valliere	Sarah	Marie
Last Name	First Name	Middle Name

N/A
Other Names Used: (Provide copies of marriage license or court records). If this does not apply to you, write N/A.

[redacted]
Mailing Address

[redacted]
Cell/Daytime Phone Number

[redacted]
City State Zip

[redacted]
Email Address

If using FCVS for verification of education, training and national medical exam scores, Check here: ☐

Date of Birth [redacted]

Social Security Number: [redacted]

SECTION 2: ALTERNATE CONTACT

You may authorize someone else to check the status of your application by providing the following information and signing below. If this section is blank, only you, the applicant, will be told the status of this application.

Name of Contact: [redacted] Phone Number: [redacted]

Name of Company: [redacted] Email: [redacted]

Address/City/State/Zip: [redacted]

I, Sarah M Valliere, give authorization for the above named person to be informed of the status of my application for licensure in Arizona.

SECTION 3: PROFESSIONAL EDUCATION

Please submit Form No. 1 to the Osteopathic College from which you graduated. The form must be completed by the school Registrar or Dean and returned ***DIRECTLY*** to the Arizona Osteopathic Board in order to provide verification of your education.

Name of College or School of Osteopathic Medicine	City/State	Graduation Date (M/D/YYYY)
University of North Texas Health Science Center Texas College of Osteopathic Medicine	Fort Worth, Texas	05/23/2015

SECTION 4: POSTGRADUATE TRAINING

Please fill in areas completely and accurately. Please submit Form No. 2 to each postgraduate training facility/program at which you trained, regardless of completion. The form must be completed by the Program Director and returned ***DIRECTLY*** to the Arizona Osteopathic Board in order to provide verification of your training. If the facilities or programs are now defunct, please so indicate. If more space is needed, use a separate sheet.

Type of Program	Name of Institution or Program	City/State	Specialty	Dates Attended	
				Start (M/D/YYYY)	End (M/D/YYYY)
Internship/ PGY-1	McGaw Northwestern	Chicago, IL	Family Medicine	06/01/2015	06/28/2018
Residency	McGaw Northwestern	Chicago, IL	Family Medicine	06/01/2015	06/28/2018
Residency					
Residency					
Fellowship	Insititute for Family Health	New York, NY	Family Planning	08/01/2018	08/01/2019
Fellowship					

SECTION 5: NATIONAL LICENSURE EXAMINATIONS

Please list the national licensure examinations you passed and the dates you passed. If you passed Level 3 of the COMLEX or Part 3 of the USMLE exam in the past seven (7) years, you must have an original transcript of all your scores sent directly to this agency. If it has been more than seven (7) years since you passed your licensing examinations, you do not need to have your scores sent to the Board but you still need to list them in the table below.

Name of Exam / Part or Level	Date Passed
COMLEX Level 1	06/18/2013
COMLEX Level 2 PE	04/25/2014
COMLEX Level 2 CE	08/14/2014
COMLEX Level 3	01/06/2017
USMLE Step 1	06/13/2013
USMLE Step 2	08/12/2014

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MAR 18 2019
AZ OSTEOPATHIC BOARD

SECTION 6: PRIMARY FIELD OF PRACTICE / BOARD CERTIFICATION OF SPECIALITIES

Please list your primary field of practice. If you are currently completing PGT, list the field in which you are training. If you are Board certified in a specialty by either AOA-BOS or a specialty board of ABMS, list those. Please write either AOA-BOS or ABMS to indicate by which Board you are certified. The Arizona Osteopathic Board does not recognize specialty certifications by other credentialing bodies. Attach a copy of each certification listed.

Primary Specialty/Field of Practice: Family Medicine

ABMS / AOA Board Specialty Certification Attach additional sheet if needed	Date Certified	Expiration Date
American Board of Family Medicine	04/13/2018	12/31/2028

SECTION 7: OTHER STATE LICENSES

Please fill in the information for each license you hold or have held. If you have more than fits in the table below, please use a separate blank sheet of paper for the 'overflow' information. If you were previously licensed in Arizona, list that also. On a separate sheet of paper explain any time you were not licensed. A verification of license must be submitted from each state in which you were granted a license, regardless of the status of the license. This verification must include a current status and disciplinary history, if any.

Issuing State	License Number	Date of Issuance	Date of Expiration	License Status
New York	293580	04/19/2018	04/30/2021	Active

SECTION 8: PRACTICE EXPERIENCE*

Provide a list of all health care facilities, clinics, urgent cares, offices, etc., at which you have practiced medicine, consulted medicine or had staff privileges, whether employed or in private practice. This list must account for all years since initial licensure. This does not include facilities at which you were doing PGT rotations. If more space is needed, please use a separate blank sheet of paper. If this information is in your CV, you may write "see CV" in the table and include your CV with your application instead.

Verification of the last seven (7) years of practice experience is required. Please send Form 3: Practice Experience Verification to the appropriate entities in order to obtain this, and then have the completed form(s) sent directly to the Board in order to maintain the integrity of the verification. We accept verifications by fax, email or mail from the verifying entities only.

** **If you have extensive Locum Tenens history, please organize by facility, then dates on a separate sheet of paper.***

Start Date (M/D/YYYY)	End Date (M/D/YYYY)	Name of Health Care Facility or Employer	City/State
N/A	N/A	N/A	N/A

Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 West Adams Street, Suite 2410, Phoenix, Arizona, 85007
Ph : 480-657-7703 | www.azdo.gov

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JUL 08 2019
#Auth 9426 $90 m
AZ OSTEOPATHIC BOARD

REQUEST FOR ISSUANCE OF LICENSE

Name: Sarah Marie Valliere, D.O. **Applicant No.:** 008014

ADDRESSES AND MAILING PREFERENCE

ADDRESSES: The Osteopathic Statutes require that you provide BOTH the address where you practice AND your home address. Your practice will be your mailing address unless you check the box for the Residential address. Please list the email you would like the Board to use to communicate with you. Email addresses are kept confidential.

Address of Record/Practice address. This address & phone number is required by ARS § 32-1803(4)(b), and shows on the Board's website. **This address will be your mailing address unless you designate otherwise in the residential address box to the right.**	**Residential address.** ☒ **By checking this box I am requesting the Board to use my Residential address as my mailing address.** Your home address and phone is required and your home city and state only will show on the Board's website if you do not provide a practice address (ARS § 32-1800(2)(b) & ARS § 32-3801).
Name of Practice:	[redacted]
Street Address:	
City, State, Zip:	
Office Number:	
Fax Number:	

RENEWAL DATES AND ISSUANCE FEE

YOUR CARD WILL BE CHARGED THE CORRESPONDING MONTH'S FEE FOR THE DATE YOUR FORM IS RECEIVED IN OUR OFFICE. REQUESTS FOR FUTURE ISSUANCES WILL *NOT* BE GRANTED.

From the Prorated Fee Table below, enter amount of fee you are paying: $ 90.00
Make your check (or money order) payable to: *AZ Board of Osteopathic Examiners.*
Visa, MasterCard and American Express are accepted. Please use the accompanying form for Credit Card Payments.

PRORATED LICENSE ISSUANCE FEES AND RENEWAL YEARS
CME is not prorated; 20 hours is required for the first year of licensure

Issue in:	Fee	Renew by Dec 31 of	Issue in:	Fee	Renew by Dec 31 of
January	$180.00	This year	July	$90.00	This year
February	$165.00	This year	August	$75.00	This year
March	$150.00	This year	September	$60.00	This year
April	$135.00	This year	October	$180.00	Next year
May	$120.00	This year	November	$180.00	Next year
June	$105.00	This year	December	$180.00	Next year

LICENSES WILL NOT BE ISSUED WITH AN EFFECTIVE DATE OF EITHER BEFORE OR AFTER THE DATE THIS FORM AND PAYMENT ARE RECEIVED IN OUR OFFICE. THE DATE YOUR FORM IS RECEIVED WILL BE YOUR ISSUANCE DATE. ISSUANCE FEES ARE NON-REIMBURSABLE.

Signature of Applicant: Sarah M Valliere Date signed: 7/2/19

Rev. 3/2018

Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 W. Adams Street #2410, Phoenix, AZ 85007
Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

July 8, 2019

Sarah Marie Valliere, D.O.
[redacted]

Dear Dr. Valliere:

RE: License Granted

On behalf of the Board of Osteopathic Examiners in Medicine and Surgery, we are pleased to grant you a license to practice osteopathic medicine and surgery in the state of Arizona. Enclosed is your wall certificate. Your professional profile at www.azdo.gov > Doctor Search is the most reliable way to verify your current license status. Receipts for your application fee and license issuance fee are enclosed.

IMPORTANT INFORMATION ABOUT YOUR LICENSE:

Your license number is:	008014
Issue/Effective date:	**July 08, 2019**
Renew By date:	December 31, 2019
Expiration if not renewed date:	May 1, 2020

LICENSE RENEWAL AND CME: This license will need to be renewed by the Renew By date listed above. Pursuant to A.R.S. § 32-1825, each licensee shall renew the license on or before January 1 and obtain 20 hours of approved CME during the same year. A minimum of 12 hours must be in AOA Category 1-A. After your first renewal at the end of your issuance year, you are required to renew your license every two years. During the two years prior to each renewal, you are required to obtain 40 hours of approved CME, 24 hours of which must be in AOA Category 1-A. Your participation in an accredited residency or fellowship program while licensed is counted as 20 AOA Category 1-A CME hours for the same year in which you participate in training.

ADDRESS OF RECORD: A.R.S. § 32-1800(2) requires the Board to maintain a public directory of all licensed osteopathic physicians. The Board recognizes the practice address you provided as your address of record. This is included in the public directory and on your public license profile. Your home address becomes your address of record if it is the only address provided. Your home address will not be posted on our website but must be disclosed to callers if it is the only address you provide. Your address of record does not need to be an Arizona address. If you have a change of address, please log in and enter it online at the Board's website within 10 days of your move.

CONTROLLED SUBSTANCE PRESCRIPTION MONITORING PROGRAM: State law requires every Arizona medical practitioner who possesses a Drug Enforcement Administration ("DEA") permit to also hold a Controlled Substances Prescription Monitoring Program ("CSPMP") registration issued by the Arizona State Board of Pharmacy ("Pharmacy Board") A.R.S. § 32-2606. You may register for the CSPMP at http://arizona.pmpaware.net.

OPTIONAL DISPENSING REGISTRATION: Your license does not include authority to dispense medications from your office. If you intend to dispense prescription medications and/or controlled substances from your office, you must complete the Initial Registration to Dispense Medication Form from the Board's website, and pay the applicable registration fee. A dispensing registration is not required if you are prescribing only or if your practice is not located in Arizona.

STATUTES AND RULES: You are expected to know Arizona Statutes and Rules governing the practice of osteopathic medicine and surgery. Please refer to the Statutes and Rules located on our website www.azdo.gov for any questions regarding your Arizona license. Should you need assistance please contact me directly at 602-771-2525 or by email at melissa.dangel@azdo.gov.

Sincerely,

Melissa Dangel

Melissa Dangel
Licensing Administrator

Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 W. Adams Street, Suite 2410, Phoenix, Arizona, 85007
Ph : 480-657-7703 | www.azdo.gov | questions@azdo.gov

Form No. 1: PROFESSIONAL EDUCATION VERIFICATION

In applying for a license to practice medicine in Arizona, the Arizona Board of Osteopathic Examiners **requires this form be completed by the Dean or the Registrar** of the osteopathic medical school from which you graduated. This is authorization to release any information in your files of record, favorable or otherwise, ***DIRECTLY*** **to the ARIZONA BOARD OF OSTEOPATHIC EXAMINERS, 1740 W. Adams Street, Suite 2410, Phoenix, Arizona, 85007.**

Applicant Name: Sarah M Valliere, D.O. Last 4 digits of SSN: [redacted]

Signature [signature] Date (Month/Day/Year) 2/23/2019

THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE OSTEOPATHIC MEDICAL SCHOOL

This certifies that Sarah Valliere, D.O.
(Name of Applicant)

was enrolled in: UNT Health Science Center / Texas College of Osteopathic Medicine
(Name of Osteopathic College of Medicine)

Fort Worth, Texas
(Location – City/State)

The undersigned further certifies that the records of this institution show that the applicant was granted an Osteopathic Medical Degree by the above named COM on: 05/16/2014 Date (Month/Day/Year)

COMMENTS:

Signature: Elizabeth Medders Date: 2/25/2019

Name Typed or Printed: Elizabeth Medders Title: Registrar

Address: 3500 Camp Bowie Blvd. Phone No.: 817-735-2201

City/State/Zip: Ft. Worth, TX 76107 Fax No.: 817-735-0448

Contact person, if different than above:

Email: registrar@unthsc.edu

TO MAINTAIN INTEGRITY OF THE VERIFICATION, SEND ORIGINAL DIRECTLY TO THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS
Completed form may be faxed with coversheet to Board office at 480-657-7715

01/2018

Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 W. Adams Street, Suite 2410, Phoenix, Arizona, 85007
Ph : 480-657-7703 | www.azdo.gov | questions@azdo.gov

Form No. 2: VERIFICATION OF POSTGRADUATE TRAINING

FOR APPLICANT: Make as many copies as needed. **Mail or fax this form to the program director of each Postgraduate Training (PGT) program in which you participated regardless of completion.** This completed form is a requirement of licensure in Arizona. Your signature below is authorization to release any information about you in your PGT program's files of record, favorable or otherwise **DIRECTLY to the Arizona Board of Osteopathic Examiners in Medicine and Surgery.**

Applicant Name: Sarah M Valliere, D.O.

Signature Sarah M Valliere Date (Month/Day/Year) 2/23/2019

THIS SECTION TO BE COMPLETED BY PROGRAM DIRECTOR

FOR PGT PROGRAM DIRECTOR: The above named individual has applied for licensure in Arizona and has stated that he/she has participated in a PGT program at your facility. He/she is required to submit this form to you for completion. Therefore, please complete this form and return it to our office at the address above.

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

PG Year(s): 1 DEPARTMENT/SPECIALTY: Family Medicine
- ○ Internship
- ⊗ Residency
- ○ Fellowship

From: 6 / 23 / 15 To: 6 / 29 / 16
Successfully completed? ⊗ Yes ○ No ○ In Progress

PG Year(s): 2 DEPARTMENT/SPECIALTY: Family Medicine
- ○ Internship
- ⊗ Residency
- ○ Fellowship

From: 6 / 30 / 16 To: 6 / 29 / 17
Successfully completed? ⊗ Yes ○ No ○ In Progress

PG Year(s): 3 DEPARTMENT/SPECIALTY: Family Medicine
- ○ Internship
- ⊗ Residency
- ○ Fellowship

From: 6 / 30 / 17 To: 6 / 29 / 18
Successfully completed? ⊗ Yes ○ No ○ In Progress

2. The following questions apply to the PGT years stated above. Please check the appropriate response.

a. This program was approved for postgraduate training during this individual's attendance by: ○ AOA ⊗ ACGME ○ DUAL

b. Did this individual ever take a leave of absence or deferment/break from his/her training? ○ Yes ⊗ No

c. Was this individual disciplined and/or placed under investigation or on probation? ○ Yes ⊗ No

d. Did this individual participate in a confidential or public diversion program for substance abuse monitoring? ○ Yes ⊗ No

Please explain below any "Yes" response(s) to the questions above. Use a separate blank sheet of paper if more room is necessary.

3. COMMENTS:

Signature: [signature] Date: 2/27/19

Name Typed or Printed: Deborah Edberg Title: Program Director

Full name of Program or Hospital: McGaw Medical Center of Northwestern University

Address: 2750 W. North Ave. Phone No.: 312-432-7206

City/State/Zip: Chicago IL 60647 Fax No.: 773-235-5804

Contact person, if different from above: Laura Schroeder Email: lschroeder@feriefamilyhealth.org

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TO MAINTAIN INTEGRITY OF THE VERIFICATION, SEND ORIGINAL DIRECTLY TO THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS
Completed form may be faxed with coversheet to Board office at 480-657-7715

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Form No. 2: VERIFICATION OF POSTGRADUATE TRAINING

FOR APPLICANT: Make as many copies as needed. **Mail or fax this form to the program director of each Postgraduate Training (PGT) program in which you participated regardless of completion.** This completed form is a requirement of licensure in Arizona. Your signature below is authorization to release any information about you in your PGT program's files of record, favorable or otherwise **DIRECTLY to the Arizona Board of Osteopathic Examiners in Medicine and Surgery.**

Applicant Name: Sarah M Valliere, D.O.

Signature Sarah M Valliere Date (Month/Day/Year) 2/23/2019

THIS SECTION TO BE COMPLETED BY PROGRAM DIRECTOR

FOR PGT PROGRAM DIRECTOR: The above named individual has applied for licensure in Arizona and has stated that he/she has participated in a PGT program at your facility. He/she is required to submit this form to you for completion. Therefore, please complete this form and return it to our office at the address above.

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

PG Year(s): 4 DEPARTMENT/SPECIALTY: Family Medicine / Family Planning

○ Internship ○ Residency ◉ Fellowship From: 8/1/18 To: 8/1/19

Successfully completed? ○ Yes ○ No ◉ In Progress

PG Year(s): _____ DEPARTMENT/SPECIALTY: _____

○ Internship ○ Residency ○ Fellowship From: ___/___/___ To: ___/___/___

Successfully completed? ○ Yes ○ No ○ In Progress

PG Year(s): _____ DEPARTMENT/SPECIALTY: _____

○ Internship ○ Residency ○ Fellowship From: ___/___/___ To: ___/___/___

Successfully completed? ○ Yes ○ No ○ In Progress

2. The following questions apply to the PGT years stated above. Please check the appropriate response.

a. This program was approved for postgraduate training during this individual's attendance by: ○ AOA ○ ACGME ○ DUAL

b. Did this individual ever take a leave of absence or deferment/break from his/her training? ○ Yes ◉ No

c. Was this individual disciplined and/or placed under investigation or on probation? ○ Yes ◉ No

d. Did this individual participate in a confidential or public diversion program for substance abuse monitoring? ○ Yes ◉ No

Please explain below any "Yes" response(s) to the questions above. Use a separate blank sheet of paper if more room is necessary.

3. COMMENTS: _____

Signature: Linda W. Prine MD Date: 2/26/19

Name Typed or Printed: Linda W. Prine MD Title: Fellowship Director

Full name of Program or Hospital: Institute for Family Health

Address: 2006 Madison Ave, NY Phone No.: 212-633-0800

City/State/Zip: NYC, NY 10035 Fax No.: 212-206-5259

Contact person, if different from above: _____ Email: lindaprine@mac.com

TO MAINTAIN INTEGRITY OF THE VERIFICATION, SEND ORIGINAL DIRECTLY TO THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS
Completed form may be faxed with coversheet to Board office at 480-657-7715

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

February 22, 2019

To Whom It May Concern:

This letter verifies Sarah Marie Valliere, D.O. (NPI: 1275929499) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 01, 2018 - * Certification Number: 1071677672

* Certification is continuous as long as Family Medicine Certification Requirements are maintained.

Family Medicine Certification Requirements:

Current Status: Meeting Requirements

Current Clinical Status: **Clinically Active**

Clinical Status History:

Jul 01, 2018 - Clinically Active

Initial display of clinical status began June 2018 and history is only shown for certified periods.

Beginning in 2011 certification by the American Board of Family Medicine is maintained through successful completion of the Family Medicine Certification process. The Family Medicine Certification process is a continuous process that requires being in compliance with Guidelines for Professionalism Licensure and Personal Conduct including maintaining a currently valid, full, and unrestricted license to practice medicine in the United States or Canada, completing certification activities in a timely fashion, and performing successfully on the examination every ten years. Failure to maintain any of these requirements will result in the loss of certification status with the ABFM. Based upon the continuous nature of Family Medicine Certification, no end date for certification is presented above.

The ABFM website serves as primary source verification. Details of the Family Medicine Certification process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh

Mary McIntosh
Verification Coordinator and Candidate Assistant

1648 McGrathiana Parkway Suite 550, Lexington KY. 40511-1247 | Ph: 877-223-7437 or 859-269-5626 | Fax: 859-335-7501 | www.theabfm.org
A Member Board of the American Board of Medical Specialties

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

ID: 173939

June 2018

Sarah Marie Valliere, D.O.
2649 N Spaulding Ave Apt 2e
Chicago, IL 60647

Dear Doctor Valliere:

CONGRATULATIONS! We are pleased to announce that you have passed the 2018 Family Medicine Certification Examination given by the American Board of Family Medicine. You may obtain a detailed analysis of your performance via a link in your Physician Portfolio. As of April 13, 2018, you have successfully completed the certification examination requirement for becoming a certified Diplomate of the American Board of Family Medicine. Certification is contingent upon meeting continuous certification requirements.

After achieving certification status, you will begin the continuous certification process for family physicians, which replaces the previous recertification process. With this continuous process, your certificate has no expiration date, but instead is valid for as long as you successfully meet the certification requirements. In general, you now have a 10-year examination requirement, and you have three years to complete each Stage of your other certification requirements.

Each 3-year Stage will have the same requirements:

- 50 certification points (acquired by completion of activities) per 3-year Stage
  - Minimum of one (1) Knowledge Self-Assessment Activity (10 points)
  - Minimum of one (1) Performance Improvement Activity (most are 20 points)
  - Additional Self-Assessment or Performance Improvement activity to reach minimum 50 points
- Completion of 150 CME Credits
- Maintain a currently valid, full, unrestricted license to practice medicine in the United States or Canada, and comply with the ABFM Guidelines for Professionalism, Licensure and Personal Conduct.

This letter does not reflect verification, only the results of your Family Medicine Certification Examination. Once you are certified, you will be able to access your certification verification letter at the ABFM website: www.theabfm.org.

Since all communication with you is done electronically, it is very important that we always have your current and valid email address. You can update this information on our website at www.theabfm.org. If you need assistance, please call the Support Center toll-free at 877-223-7437.

Our best wishes for your continued success.

Sincerely,

James C. Puffer

James C. Puffer, M.D.

President and Chief Executive Officer

1648 McGrathiana Pkwy, Ste. 550 | Lexington, KY 40511-1247 | Ph: 859-269-5626 or 888-995-5700 | Fax: 859-335-7501 | www.theabfm.org
A Member Board of the American Board of Medical Specialties

Arizona Board of Osteopathic Examiners

OBEX - Doctor of Osteopathic Medicine - Confirmation (Step 7 of 8)
1/5/2022

Dr. Sarah Marie Valliere

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.

Practice Address

Current Practice Address

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

Home Address

Current Home Address

[redacted] to enter a valid address, if you have one.

Mailing Address

Current Mailing Address

[redacted]

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

General Questions

During the past two (2) years, have you been notified or made aware:

1) That you were arrested for, charged with or convicted of a felony, or any misdemeanor? You must answer "yes" even if the offense occurred outside of Arizona, the case has not yet been adjudicated, you completed a diversion program, you received a suspended sentence or probation, the convictions were dismissed or set aside, your sentence was commuted, the records were expunged, your civil rights were restored, or you received a pardon.
[redacted]

2) That you had disciplinary or adverse action imposed against any professional license, or that you were denied a professional license, or that you entered into any consent agreement, stipulated order, or settlement with any regulatory board other than the Arizona Osteopathic Board; Or have you been notified of any complaints or investigations against your license that have not yet been resolved?
[redacted]

3) That your DEA permit or prescription permit issued by any regulatory board was denied, restricted, suspended, lost, or had any other adverse action taken against it; Or have you been notified of any complaints or investigations against your authority to prescribe that have not yet been resolved?
[redacted]

4) That any award, settlement, or payment of any kind was made by you or on your behalf to resolve a civil suit or malpractice claim involving your practice?
[redacted]

5) That your hospital privileges or health care program affiliations were denied, restricted, lost, suspended, or modified, or subjected to any other adverse action, even if that action was not required to be reported to the National Practitioner Data Bank; Or have you been notified of any complaints against or reviews of your privileges or affiliations that have not yet been resolved?

[redacted]

Confidential Questions

Since your initial application or last renewal (whichever is more recent), have you been notified or made aware:

1. Have you been notified, diagnosed with or made aware of any initial or worsening symptoms of a current condition which did or may impair or limit your ability to safely practice medicine?

[redacted]

2. That you entered into a diversion program for evaluation, treatment or monitoring for substance abuse or dependency, or for correction of communication or boundary issues, in lieu of or as a condition of resolving a matter before a regulatory board, criminal or civil court; OR have you been notified that such action is pending? You must answer "Yes" even if you received a pardon, the convictions were set aside, the records were expunged, your civil rights were restored and whether or not the sentence was imposed or suspended.

[redacted]

Area of Specialty Section

The following are the specialties currently on record.

	Specialty/Area of Interest	AOA Certified	ABMS Certified	Not Certified	Date Certified	Expiration Date
Primary Specialty	Family Medicine	No	Yes	No	07/01/2018	12/31/2028
Specialty 2		No	No	Yes		
Specialty 3		No	No	Yes		
Specialty 4		No	No	Yes		
Specialty 5		No	No	Yes		
Specialty 6		No	No	Yes		

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

1. By clicking the "confirm" button below, I attest that I have completed at least forty (40) hours of CME which included at least twenty-four (24) hours of AOA Category 1-A CME during the two (2) calendar years preceding my renew by date for renewal of my license or have submitted a waiver or extension as set forth in A.R.S. § 32-1825(B) and A.A.C. R4-22-207. If during this renewal I was asked to provide a list of CME completed, I understand I must submit documentation of CME to the Board.

2. By clicking the "confirm" button below, I am certifying under penalty of perjury that the above information and any documents submitted in support of this renewal application are true, correct, and complete and that I understand that any false statements and/or misrepresentations could result in disciplinary action taken against my license.

☑ **Confirm**

You may wish to print this Page for your records.

Back Next

OBEX - Doctor of Osteopathic Medicine - Confirmation (Step 7 of 8)

11/20/2019

Dr. Sarah Marie Valliere

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.

Practice Address

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.

General Questions

During the past two (2) years, have you been notified or made aware:

1) That you were arrested for, charged with or convicted of a felony, or any misdemeanor? You must answer "yes" even if the offense occurred outside of Arizona, the case has not yet been adjudicated, you completed a diversion program, you received a suspended sentence or probation, the convictions were dismissed or set aside, your sentence was commuted, the records were expunged, your civil rights were restored, or you received a pardon.
[redacted]

2) That you had disciplinary or adverse action imposed against any professional license, or that you were denied a professional license, or that you entered into any consent agreement, stipulated order, or settlement with any regulatory board other than the Arizona Osteopathic Board; Or have you been notified of any complaints or investigations against your license that

have not yet been resolved?

3) That your DEA permit or prescription permit issued by any regulatory board was denied, restricted, suspended, lost, or had any other adverse action taken against it; Or have you been notified of any complaints or investigations against your authority to prescribe that have not yet been resolved?

4) That any award, settlement, or payment of any kind was made by you or on your behalf to resolve a civil suit or malpractice claim involving your practice?

5) That your hospital privileges or health care program affiliations were denied, restricted, lost, suspended, or modified, or subjected to any other adverse action, even if that action was not required to be reported to the National Practitioner Data Bank; Or have you been notified of any complaints against or reviews of your privileges or affiliations that have not yet been resolved?

Confidential Questions

Since your initial application or last renewal (whichever is more recent), have you been notified or made aware:

1. Have you been notified, diagnosed with or made aware of any initial or worsening symptoms of current condition which did or may impair or limit your ability to safely practice medicine?

2. That you entered into a diversion program for evaluation, treatment or monitoring for substance abuse or dependency, or for correction of communication or boundary issues, in lieu of or as a condition of resolving a matter before a regulatory board, criminal or civil court; OR have you been notified that such action is pending? You must answer "Yes" even if you received a pardon, the convictions were set aside, the records were expunged, your civil rights were restored and whether or not the sentence was imposed or suspended.

Area of Specialty Section

The following are the specialties currently on record.

	Specialty/Area of Interest	AOA Certified	ABMS Certified	Not Certified	Date Certified	Expiration Date
Primary Specialty	Family Medicine	No	Yes	No	07/01/2018	12/31/2028
Specialty 2		No	No	Yes		
Specialty 3		No	No	Yes		
Specialty 4		No	No	Yes		
Specialty 5		No	No	Yes		
Specialty 6		No	No	Yes		

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

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Confirm

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Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 W. Adams Street, Suite 2410, Phoenix, Arizona 85007
Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

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INITIAL REGISTRATION TO DISPENSE MEDICATION FORM

Use this form is you are applying for a Dispensing Physician Registration for the first time, or if you allowed your Dispensing Physician Registration to expire.

In accordance with A.R.S. § 41-1030 The Board is required to notify you of the following:

B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.
D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.
E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.
F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

PLEASE NOTE: A *separate* DEA certificate must be submitted for *EACH* location where scheduled drugs will be dispensed and must be kept current for that location during the registration period

PLEASE TYPE OR PRINT – IF PDF, FORM FIELDS CAN BE FILLED IN ELECTRONICALLY

Physician Name: Sarah M. Valliere D.O. Date: 11/25/2019 License # 008014

Licensee DEA Certificate #: _____ Issue Date: _____ Expiration Date: _____

E-mail (required--*your certificate(s) will be sent to you by email*): [redacted]

PRIMARY PRACTICE: LIST YOUR PRIMARY PRACTICE BELOW. LIST ANY ADDITIONAL LOCATIONS ON THE SECOND PAGE OF THIS FORM.

Name of Primary Practice: Planned Parenthood

Street Address: 1837 E. Baseline Road Phone #: 602.277.7526

City/State/Zip: Tempe, AZ 85283 Fax #: 602.296.0154

DEA # for This Location: [redacted] Issued Date: 10-17-2019 Exp Date: 05-31-2022

Schedule 2 Drugs	☒ Beginning April 26, 2018, prescribers can no longer dispense schedule II opioids, except for MAT for substance abuse.	Schedule 4 Drugs	☒	Prescription Only Drugs	☒
Schedule 3 Drugs	☒	Schedule 5 Drugs	☒	Prescription Devices	☒

☒ $ 240 *prorated fee for Initial Registration to Dispense for the current calendar year, valid until December 31 of the current year (Please use the fee table at the bottom of the form to determine your fee requirements)*

☐ *My practice / dispensing is not for profit. (Include documentation of your organization's current 501(c)(3) status in order to qualify for the fee waiver)*

INITIAL PRORATED REGISTRATION FEE (A.R.S. §32-1826(A)(11))

January	$240.00	July	$120.00
February	$220.00	August	$100.00
March	$200.00	September	$ 80.00
April	$180.00	October (registration thru Dec next year)	$240.00
May	$160.00	November (registration thru Dec next year)	$240.00
June	$140.00	December (registration thru Dec next year)	$240.00

I hereby attest that I am in compliance with the laws and rules regarding dispensing. I understand this registration expires on December 31st if not renewed.

Physician Signature _____ Date signed 11/25/2019

12/2018