

## Arizona Medical Board – License Application

Milton Bird McColl

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.

### Personal Information

Name  
Tracking Number:  
City of Birth:  
State of Birth:  
Country of Birth  
Existing Alias Names

Milton Bird McColl



### General Questions

Note: In the event the response to any of the questions numbered 1 through 11 is "YES", you must file by email 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.

Have you had an application for medical licensure denied or rejected by another state or province licensing board?

Yes  No

If Yes, describe

Have you had any disciplinary or rehabilitative action been taken against you by another licensing board, including other health professions?

Yes  No

If Yes, describe

Have you had any disciplinary actions, restrictions or limitations taken against you while participating in any type of training program or by any hea

Yes  No

If Yes, describe

Have you ever been found in violation of a statute, rule, or regulation of any domestic or foreign governmental agency?

Yes  No

If Yes, describe

Are you currently under investigation by any medical board or peer review body?

Yes  No

If Yes, describe

Have you ever had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancel

Yes  No

If Yes, describe

Have you had hospital privileges revoked, denied, suspended, or restricted?

Yes  No

If Yes, describe

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

Yes  No

If Yes, describe

Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice

Yes  No

If Yes, describe

Have you had your authority to prescribe, dispense, or administer medications limited, restricted, modified, denied, surrendered, or revoked by a fede

Yes  No

If Yes, describe

Have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state?

Yes  No

If Yes, describe



**Confidential Questions**

Within the last five years have you received treatment for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narc



This question has been deleted.



**Citizenship Status**

Certified copy of passport

A drivers license issue by a state that verifies lawful presence in the United State

### **Specialties**

<b>Specialty</b>	<b>ABMS Certified</b>	<b>Practicing</b>	<b>Expiration Date</b>	<b>Lifetime Certified</b>
Family Medicine	Yes	Yes	12/31/2029	No

### **Practice Address**

(Directory Address)

Planned Parenthood

1837 E Baseline Rd

Tempe AZ 85283

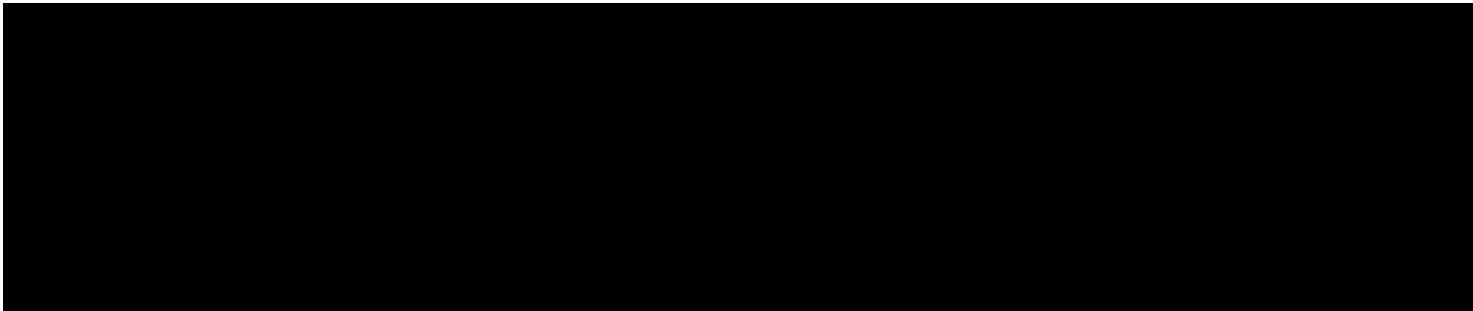
County Maricopa

Country USA

Phone: (602) 277-7526

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

### **Home Address**



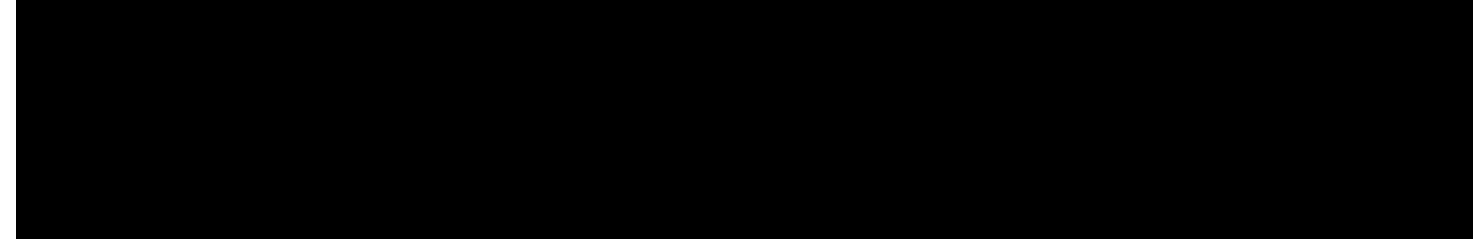
### **Mailing Address**

1837 E Baseline Rd

Tempe AZ 85283

County Maricopa

Country United States



### **Other State Licenses**

<b>State Board</b>	<b>License No.</b>	<b>Date Issued</b>	<b>License Status</b>
Oklahoma Board of Medical Licensure and Supervision	36904	6/16/2020	Active
Medical Board of California	G68043	2/13/1990	Active
Nevada State Board of Medical Examiners	LL3080	2/1/2018	Expired
Kansas State Board of Healing Arts	xxxxxx	12/31/2020	Pending

**Medical Education**

ECFMG No:

I am applying via Fifth Pathway.

0

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

0

School Name	City	State	Country	Degree Date
Stanford University School of Medicine	Stanford	CA	USA	03/31/1988

**Post Graduate Programs**

Institution Name	City	State	Type of Program	Specialty	Dates
Santa Clara Valley Medical Center	San Jose	CA	Internship	General Practice	04/01/1988- 11/24/1989
Stanford /O'Connor Family Medicine	San Jose	CA	Resident	Family Medicine	06/15/2016- 06/30/2019

**License Exams**

National Board of Medical Examiners Examination (NBME) Certification Date  
12/01/1989

**Medical Employment**

Employer Name	Address	City	State	Zip	Country	Dates
Planned Parenthood Great Plains	619 NW 23rd St	Oklahoma City	OK	73103	usa	08/01/2020- 12/03/2020
Santa Clara Valley Medical Center	143 N Main St	Milpitas	CA	95035	usa	10/01/2019- 12/03/2020

**MD Training Unit Complete**

Click to download the above mentioned forms.

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 click . All felonies are reportable.

**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.**

You may wish to print this Page for your records.  Submit

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

<a href="#">Back</a>	<a href="#">Save and Logout</a>	<a href="#">Next</a>
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Have questions? Please contact us at 480-551-2700







Kristin Colafranceschi &lt;kristin.colafranceschi@azmd.gov&gt;

**Re: Deficiency Notice Arizona Medical Board**

1 message

**Milt Mccoll** [REDACTED]

Sat, Dec 19, 2020 at 12:17 PM

To: Kristin Colafranceschi &lt;kristin.colafranceschi@azmd.gov&gt;, Milt Mccoll &lt;miltmccollmd@gmail.com&gt;

thanks - photo attached  
Can you confirm the photo is acceptable?  
thanks

**Milt McColl MD**  
[REDACTED]

On Fri, Dec 18, 2020 at 9:58 AM Kristin Colafranceschi &lt;kristin.colafranceschi@azmd.gov&gt; wrote:

Dear Dr. McColl,  
We do not have a specific form for employment verifications. You can request your employer send a letter on their letterhead, verifying your employment and dates. They can send the verification directly to my email address.

Please send a current color photo to my email address as we do not accept the photo from the FCVS packet.

Thank you.

Sincerely,

**Kristin Colafranceschi**, Senior Licensing Coordinator

(480) 551-2761

[Kristin.colafranceschi@azmd.gov](mailto:kristin.colafranceschi@azmd.gov)

Arizona Medical Board  
1740 W. Adams, Suite 4000  
Phoenix, AZ 85007

On Fri, Dec 18, 2020 at 10:23 AM Milt Mccoll [REDACTED] wrote:

Kristin  
Thank you for your response and the attachments.

for the letters from my employers- is there a form they need to fill out or is there a standard letter they use? do they just need to state the dates of my employment and that I am in good standing? ( I am currently employed by both of them so it will not have an end date). I understand these need to be mailed directly from the employer correct?

On the photo the attached was sent to FCVS (see attached notarized copy and a copy of my passport was also sent to FCVS) . I presume this will work for my ID - and passport verification once they forward it to you.

Do I still need an additional photo sent directly to you ( emailed) or will the one from FCVS or the one attached suffice ? I will sign and have notarized the affidavit you have sent for my online application.

The rest should be forthcoming from FCVS shortly.

Regards,

**Milt McColl MD**  
[REDACTED]

On Thu, Dec 17, 2020 at 1:34 PM Kristin Colafranceschi <[kristin.colafranceschi@azmd.gov](mailto:kristin.colafranceschi@azmd.gov)> wrote:

Dear Dr. McColl,

Every FCVS packet is unique to each physician. The items that we usually receive in an FCVS packet would be your notarized US Passport, Medical School Transcripts, Postgraduate Training Verification and Exam scores. Thank you.

Sincerely,

**Kristin Colafranceschi**, Senior Licensing Coordinator

(480) 551-2761

[Kristin.colafranceschi@azmd.gov](mailto:Kristin.colafranceschi@azmd.gov)

Arizona Medical Board

1740 W. Adams, Suite 4000

Phoenix, AZ 85007

On Thu, Dec 17, 2020 at 2:29 PM Milt Mccoll [REDACTED] wrote:

Thank you. I will review in detail.

I am trying to use FCVS but this is my first attempt to use them. Hopefully they will provide most of the mentioned documents for me. I will provide the rest as requested.

On Thu, Dec 17, 2020 at 12:50 PM Kristin Colafranceschi <[kristin.colafranceschi@azmd.gov](mailto:kristin.colafranceschi@azmd.gov)> wrote:

Dear Dr. McColl,

The attached deficiency letter will not be sent by US Mail unless requested.

Sincerely,

**Kristin Colafranceschi**, Senior Licensing Coordinator

(480) 551-2761

[Kristin.colafranceschi@azmd.gov](mailto:Kristin.colafranceschi@azmd.gov)

Arizona Medical Board

1740 W. Adams, Suite 4000

Phoenix, AZ 85007

--  
**Milt McColl MD**



**passport photo.jpg**  
999K



# MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advocating high quality, safe medical care.

## Licensing Program

2005 Evergreen Street, Suite 1200  
Sacramento, CA 95815-5401  
Phone: (916) 263-2382  
Fax: (916) 263-2487  
www.mbc.ca.gov

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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

January 7, 2021

Arizona Medical Board  
1740 W Adams St, Suite 4000  
Phoenix, AZ 85007

To Whom It May Concern:

This is to certify that as of January 7, 2021, the records of the Medical Board of California (Board) indicate the following information:

Physician:	MILTON BIRD MCCOLL
License Number:	G68043
Issued Date:	February 13, 1990
Exam Type:	A Written Examination
Expiration Date:	August 31, 2021
License Status:	CURRENT
Board Discipline and/or Administrative Action:	No

If Board Discipline and/or Administrative Action is indicated, public records may be available at <http://www.mbc.ca.gov>; or you may contact the Board's Enforcement Program, Central File Room by email at [centralfileroom@mbc.ca.gov](mailto:centralfileroom@mbc.ca.gov), by fax at (916) 263-2420 or by mail at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain information concerning the action.

Marina O'Connor  
Chief of Licensing

# Board of Medical Licensure & Supervision State of Oklahoma

101 N.E. 51st Street  
Oklahoma City, OK 73105



P.O. Box 18256  
Oklahoma City, OK 73154-0256

## Letter of Verification

January 07, 2021

This is to certify that the records of this Board indicate on the date of this letter the following information regarding:

Name: MILTON B MCCOLL  
Address Date: September 13, 2020  
Address 1: VALLEY MEDICAL CENTER  
Address 2: 143 N MAIN ST  
Address 3:  
City, State, ZIP: MILPITAS, CA 95035-4322

Profession: MEDICAL DOCTOR  
Profession Type: MD  
License Number: 36904  
License Date: 06/16/2020  
Status: Active  
Status Class:  
Expiration Date: 06/01/2021  
Endorsed By: NBME  
Restricted To:

### Disciplinary Actions:

Date	Description
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No Disciplinary Actions Taken

### Previous Licenses:

Type	Issued	Expired
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Details of Disciplinary Action, if applicable, will be made available by photocopy from the public file upon written request only.

To expedite the verification of licensure/certification process, the above is the standard format for all professions regulated by this board

**The Oklahoma State Board of Medical Licensure and Supervision certifies that the verification data displayed here is accurate according to the information stored in our database as of 01/07/2021.**

Lisa Cullen  
Director of Licensing  
(405) 962-1400 ext 153



Licensing Report - MEDICAL BOARD &lt;licensingreport@azmd.gov&gt;

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**License Verification Statement - MCCOLL, MILTON (M.D.)**

1 message

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**support@veridoc.org** <support@veridoc.org>  
To: Licensingreport@azmd.gov

Thu, Jan 7, 2021 at 8:43 PM

**Verification of License Status**

The attached verification reports have been sent to you by the VeriDoc.org website. This email can be verified as coming from this site by clicking on the link below.

[Validate Verifications](#)

Physician: MCCOLL, MILTON

Transaction ID: 866119


Confirmation Number: 17814619913515323321

This email contains 2 PDF attachments. If any are missing please contact [support@veridoc.org](mailto:support@veridoc.org)

Information from the attached verifications can be refreshed for up to 6 months. To view an updated copy, click on a link below.

[California, Medical Board of](#)[Oklahoma Board of Medical License & Supervision](#)

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**2 attachments** **v866119AA.pdf**  
103K **v866119BA.pdf**  
97K



Kansas State Board of Healing Arts  
800 SW Jackson, Suite A-Lower Level  
Topeka, KS 66612



Phone: 785-296-7413  
Fax: 785-368-7103  
KSBHA\_healingarts@ks.gov  
www.ksbha.org

Tucker Poling, Interim Executive Director

Laura Kelly, Governor

January 12, 2021

Arizona Medical Board  
1740 W Adams St, Suite 4000  
Phoenix, AZ 85007

This is to certify that: Milton Bird McColl has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

License Number:	04-44239
Year of Birth:	[REDACTED]
Profession:	MD Active License
License Status:	Current
Original License Date:	01/08/2021
Expiration Date:	07/31/2021
Disciplinary Action:	No



Please visit [www.KSBHA.org](http://www.KSBHA.org) to view Board Actions available to the public. To receive certified copies of Board Actions, please email [KSBHA\\_openrecords@ks.gov](mailto:KSBHA_openrecords@ks.gov). All communications to the Board must include the name and license number of the licensee.

**Board Members:** Steven J. Gould, DC, President, Cheney • John F. Settich, Ph.D., Public Member, Vice President, Atchison • Mark Balderston, DC, Shawnee  
Molly Black, MD, Shawnee • R. Jerry DeGrado, DC, Wichita • Robin D. Durrett, DO, Great Bend • Tom Estep, MD, Wichita  
Joel R. Hutchins, MD, Holton • Steve Kelly, Public Member, Newton • David Laha, DPM, Overland Park • Douglas J. Milfield, MD, Wichita  
Garold O. Minns, MD, Bel Aire • Kimberly J. Templeton, MD, Leawood • Ronald M. Varner, DO, Augusta • Sherri Wattenbarger, Public Member, Overland Park

TTY (Hearing Impaired) 711 or 1.800.766.3777 voice/TTY • e-mail: [KSBHA\\_healingarts@ks.gov](mailto:KSBHA_healingarts@ks.gov)





Licensing Report - MEDICAL BOARD &lt;licensingreport@azmd.gov&gt;

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**License Verification Statement - McColl, Milton**

1 message

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**support@veridoc.org** <support@veridoc.org>  
To: Licensingreport@azmd.gov

Tue, Jan 12, 2021 at 12:04 PM

**Verification of Licensure Status**

The attached verification report has been sent to you by the VeriDoc.org website. This email can be verified as coming from this site by clicking on the link below.

[Validate Verifications](#)

Physician: McColl, Milton


Transaction ID: 867381

Confirmation Number: 16113223127165118226

Information from the attached verification can be refreshed for up to 6 months. To view an updated copy, click on link below.

[Kansas State Board of Healing Arts](#)

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 **v867381AA.pdf**  
298K

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:

*Michael B. McNeal*

Date:

1/6/2021

Notarization

Subscribed and sworn in front of me by \_\_\_\_\_, personally appearing on this date \_\_\_\_\_.

Applicant Name Print or Type

SEE ATTACHED

NOTARIAL CERTIFICATE  
Notary Public's Signature

(Personalized Seal)

**CALIFORNIA JURAT WITH AFFIANT STATEMENT**

**GOVERNMENT CODE § 8202**

- See Attached Document (Notary to cross out lines 1-6 below)
- See Statement Below (Lines 1-6 to be completed only by document signer[s], not Notary)

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

6 \_\_\_\_\_

\_\_\_\_\_  
*Signature of Document Signer No. 1*

\_\_\_\_\_  
*Signature of Document Signer No. 2 (if any)*

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California  
 County of SANTA CLARA

Subscribed and sworn to (or affirmed) before me  
 on this 6<sup>TH</sup> day of JANUARY, 2021,  
 by \_\_\_\_\_  
Date Month Year

(1) MILTON BIRD MCCOLL

(and (2) \_\_\_\_\_),  
Name(s) of Signer(s)



proved to me on the basis of satisfactory evidence  
 to be the person(s) who appeared before me.

Signature *Nina Randall*  
Signature of Notary Public

*Place Notary Seal Above*

**OPTIONAL**

*Though this section is optional, completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.*

**Description of Attached Document**

Title or Type of Document: ARIZONA MEDICAL BOARD MD INITIAL AND ENDORSEMENT LICENSE APPLICATION - ATTESTATION Document Date: \_\_\_\_\_

Number of Pages: 7 of 9 Signer(s) Other Than Named Above: \_\_\_\_\_



Kristin Colafranceschi <kristin.colafranceschi@azmd.gov>

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## Mccoll attestation

1 message

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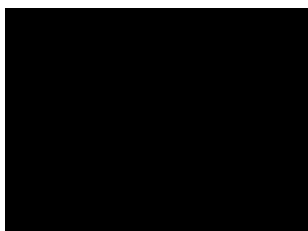
**Milt Mccoll** [REDACTED] Wed, Jan 6, 2021 at 1:03 PM  
To: Kristin Colafranceschi <kristin.colafranceschi@azmd.gov>, Milt Mccoll [REDACTED]

Kristin

Attached is my notarized attestation. Please confirm this is adequate. In addition I have sent the fingerprint documents for arrival tomorrow to the address on the envelope.

Please let me know if there are any other deficiencies for me.

Can you also confirm that you received the FCVS package? And that all of that is adequate?



pdf



## Arizona Medical Board

1740 W. Adams, Suite 4000 • Phoenix, AZ 85007

Telephone: 480-551-2700 • Fax: 480-551-2704

Website: [www.azmd.gov](http://www.azmd.gov)

December 17, 2020

Milton Bird McColl, M.D.  
1837 E Baseline Rd  
Tempe, AZ 85283

Email Address: [REDACTED]

Dear Dr. McColl:

Please accept this letter as receipt of your application for licensure to practice medicine in the State of Arizona. I reviewed your application submission. To complete the processing of your application, the following documentation is still required:

1. **Submit a full set of fingerprints to the board for the purpose of obtaining a state and federal criminal records check.**  
The Board mailed a Fingerprint Packet to your current mailing address. You should receive the packet in approximately 5 working days. **Please follow the directions exactly, to avoid any delay in processing your application.**
2. **Headshot photograph of passport quality** (*Photograph must not be taken more than 60 days before the date of the application – Photograph may be emailed*)
3. **Evidence Certificate of Identification** (is included with the Online and Paper Applications or may be obtained from the Board).
  - a. A copy of a Birth Certificate and a copy of government issued photo ID (a form may be obtained from the Medical Board), OR
  - b. A copy of a Passport to include a Notarized copy of the Certificate of Identification form), OR
  - c. Certified Copy of US Birth Certificate (Office of Vital Records from the state you were born) and copy of government issued photo ID, OR
  - d. Certified Copy of US Passport (Department of State)
4. **Notarized and Signed Online Application Attestation** (*attached*)
5. **Medical College Certification for National Graduates**  
One of the following must be submitted directly from your medical school to the Board:
  - a. An official copy or your medical school transcripts, OR
  - b. A copy of your diploma, or
  - c. A letter with an official letterhead that confirms successful completion
6. **12 months ACGME Approved Postgraduate Training Verification**
  - a. **Santa Clara Valley Medical Center for the period of 04/01/1988 to 11/24/1989**
  - b. **Stanford /O'Connor Family Medicine for the period of 06/15/2016 to 06/30/2019**U.S. or Canadian Graduates: 12 months of ACGME and/or RCPSC approved post graduate training
7. **NBME Exam Scores** (available online at [www.nbme.org](http://www.nbme.org))
8. **Verification of other state(s) licenses: CA and OK**  
License verification is required to be sent directly to the Board from **each** state or province in which you hold or held a license. Verification(s) of training permits or registrations are **not** required. If you obtain a license during the licensure process, you must request the verification to be sent directly to the Board. \*The Board accepts verifications from Veridoc.
9. **Medical Employment verification(s) during the five years before the date of the application**  
Verification(s) of all medical employment must be sent directly to the Board.
  - a. Planned Parenthood Great Plains

b. Santa Clara Valley Medical Center

\*Note: Some information may be provided in an FCVS Packet, if you use their service. Upon further review, additional information may be requested.

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 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 of the required 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,

Kristin Colafranceschi  
Senior Licensing Coordinator  
480.551.2761  
[Kristin.colafranceschi@azmd.gov](mailto:Kristin.colafranceschi@azmd.gov)

Arizona Medical Board  
1740 W. Adams, Suite 4000  
Phoenix, AZ 85007

# County of Santa Clara

Employee Services Agency

Employee Benefits

2325 Enborg Lane, Room 1H105

San Jose, California 95128



December 29, 2020

To whom it may concern:

Milton McColl MD is currently employed by Santa Clara Valley Medical Center effective 10/21/2019.

Please feel free to contact me if you have further questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Vanessa N. Madrigal". The signature is fluid and cursive, with a large initial "V" and "M".

*Vanessa N. Madrigal*

ESA Health & Hospital System - Human Resources

2325 Enborg Ln. Suite 1H105 San Jose, CA 95128

Office: 408.885.3303 | Fax: 408.885.6459

Email: [vanessa.madrigal@esa.sccgov.org](mailto:vanessa.madrigal@esa.sccgov.org)



Kristin Colafranceschi &lt;kristin.colafranceschi@azmd.gov&gt;

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**RE: [EXTERNAL] Letter for AZ medical license application**

1 message

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**Madrigal, Vanessa** <vanessa.madrigal@esa.sccgov.org>

Tue, Dec 29, 2020 at 3:31 PM

To: [REDACTED] "Kristin.colafranceschi@azmd.gov"

&lt;Kristin.colafranceschi@azmd.gov&gt;

Cc: "Perez, Luz" &lt;Luz.Perez@esa.sccgov.org&gt;

Please find attachment.

Thank you,

Vanessa

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**From:** McColl, Milton [REDACTED]**Sent:** Tuesday, December 29, 2020 1:31 PM**To:** Milt Mccoll [REDACTED] Madrigal, Vanessa <vanessa.madrigal@esa.sccgov.org>**Cc:** Milt Mccoll [REDACTED]**Subject:** Re: [EXTERNAL] Letter for AZ medical license application

By the way an email should be sufficient from what I understand with your logo and title- just a one line statement

Get [Outlook for iOS](#)

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**From:** Milt Mccoll [REDACTED]**Sent:** Monday, December 28, 2020 7:37:10 PM**To:** Madrigal, Vanessa <vanessa.madrigal@esa.sccgov.org>**Cc:** Perez, Luz <Luz.Perez@esa.sccgov.org>; Alcalá, Rosalba <Rosalba.Alcala@hhs.sccgov.org>; McColl, Milton [REDACTED]**Subject:** Re: [EXTERNAL] Letter for AZ medical license application

Vanessa

can you confirm you received this message and that you have sent the confirmation of employment to Arizona Medical Board ( per above- The letter only needs to state the date of my employment ( I started at VMC in October 2019 ) and that I am still working at VMC. It has to be on VMC letterhead It just needs to be emailed to Kritin at the AZ medical board [Kristin.colafranceschi@azmd.gov](mailto:Kristin.colafranceschi@azmd.gov) )

thanks

**Milt McColl MD**

[REDACTED]



On Mon, Dec 21, 2020 at 9:18 AM McColl, Milton [REDACTED] wrote:

Vanessa

Nice to talk with you again

I am applying for an Arizona Medical license. The AZ state medical board requires a letter from any employer that I am currently doing clinical work. The letter only needs to state the date of my employment ( I started at VMC in October 2019 ) and that I am still working at VMC. It has to be on VMC letterhead . It just needs to be emailed to Kristin at the AZ medical board

[Kristin.colafranceschi@azmd.gov](mailto:Kristin.colafranceschi@azmd.gov)

Can you let me know once the letter is sent?

Thanks

Dr McColl

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**From:** Perez, Luz <[Luz.Perez@esa.sccgov.org](mailto:Luz.Perez@esa.sccgov.org)>

**Sent:** Monday, December 21, 2020 9:16 AM

**To:** Alcalá, Rosalba <[Rosalba.Alcala@hhs.sccgov.org](mailto:Rosalba.Alcala@hhs.sccgov.org)>; Milt Mccoll [REDACTED] McColl, Milton [REDACTED] Madrigal, Vanessa <[vanessa.madrigal@esa.sccgov.org](mailto:vanessa.madrigal@esa.sccgov.org)>

**Subject:** RE: [EXTERNAL] Letter for AZ medical license application

Yes, Vanessa can go ahead and provide.

Regards,

Luz Perez, HR Supervisor

HHS Dept. of Human Resources

[2325 Enborg Ln, Suite 1H105](#)

408-885-5453 (p) | 408-885-6459 (f)



ALWAYS HAVE COUNTY BENEFITS  
INFORMATION AT YOUR FINGERTIPS

Save our **MobileBenes** website to your phone's home screen!  
[HTTPS://SCC.MOBILEBENES.COM/](https://scc.mobilebenes.com/)

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**From:** Alcalá, Rosalba <[Rosalba.Alcala@hhs.sccgov.org](mailto:Rosalba.Alcala@hhs.sccgov.org)>

**Sent:** Monday, December 21, 2020 9:05 AM

**To:** Milt Mccoll [REDACTED] Madrigal, Vanessa  
<[vanessa.madrigal@esa.sccgov.org](mailto:vanessa.madrigal@esa.sccgov.org)>; Perez, Luz <[Luz.Perez@esa.sccgov.org](mailto:Luz.Perez@esa.sccgov.org)>

**Subject:** RE: [EXTERNAL] Letter for AZ medical license application

Hi Vanessa/ Luz,

Please see below, employment verification request from one of our doctors. Is this something you can provide?

Thanks,

Rosalba

**From:** Milt Mccoll [REDACTED]

**Sent:** Saturday, December 19, 2020 11:39 AM

**To:** Alcalá, Rosalba <[Rosalba.Alcala@hhs.sccgov.org](mailto:Rosalba.Alcala@hhs.sccgov.org)>; McColl, Milton [REDACTED] Milt Mccoll  
[REDACTED]

**Subject:** [EXTERNAL] Letter for AZ medical license application

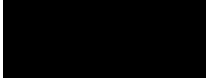
Rosalba

I am applying for an Arizona Medical license. The AZ state medical board requires a letter from any employer that I am currently doing clinical work. The letter only needs to state the date of my employment ( I started at VMC in October 2019 ) and that I am still working at VMC. It has to be on VMC letterhead .

Are you or someone in your office the right person to write such a letter? It just needs to be emailed to Kritin at the AZ medical board [Kristin.colafranceschi@azmd.gov](mailto:Kristin.colafranceschi@azmd.gov)

Please let me know if that will work ( or who to send this request to) and once such a letter is sent please let me know so I can confirm she received it

thanks,

**Milt McColl MD**

NOTICE: This email message and/or its attachments may contain information that is confidential or restricted. It is intended only for the individuals named as recipients in the message. If you are NOT an authorized recipient, you are prohibited from using, delivering, distributing, printing, copying, or disclosing the message or content to others and must delete the message from your computer. If you have received this message in error, please notify the sender by return email.

**Mcoll.pdf**  
37K



Kristin Colafranceschi &lt;kristin.colafranceschi@azmd.gov&gt;

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**Contract Physician Verification**

1 message

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**Folly, Julia** <julia.folly@ppgreatplains.org>  
To: "Kristin.colafranceschi@azmd.gov" <Kristin.colafranceschi@azmd.gov>  
Cc: Milt Mccoll [REDACTED]

Tue, Dec 29, 2020 at 8:47 AM

Good Morning Kristin,

Dr. Milton Mccoll has been a contract physician with Planned Parenthood Great Plains since August 2020 and is currently active.

Let me know if you need anything further,

--

Julia Folly

Human Resources Business Partner

Cell: 612-323-8327

Confidential Fax: 913-469-3654 *(fax receipt may be delayed due to limited on-site office hours)*



Planned Parenthood Great Plains

[PPGP is Hiring!](#)



## Arizona Medical Board

1740 W. Adams St., Suite 4000 • Phoenix, AZ 85007  
Telephone: 480- 551-2700 • Toll Free: 877-255-2212  
Website: [www.azmd.gov](http://www.azmd.gov)

February 5, 2021

Milton Bird McColl, M.D.  
1837 E Baseline Rd  
Tempe, AZ 85283

Dear Dr. McColl,

The Arizona Medical Board is pleased to inform you that your application for licensure has been approved. Your license number will be **62712**. Your license will be activated upon receipt of the required license issuance fee of **\$125.00**. **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 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.

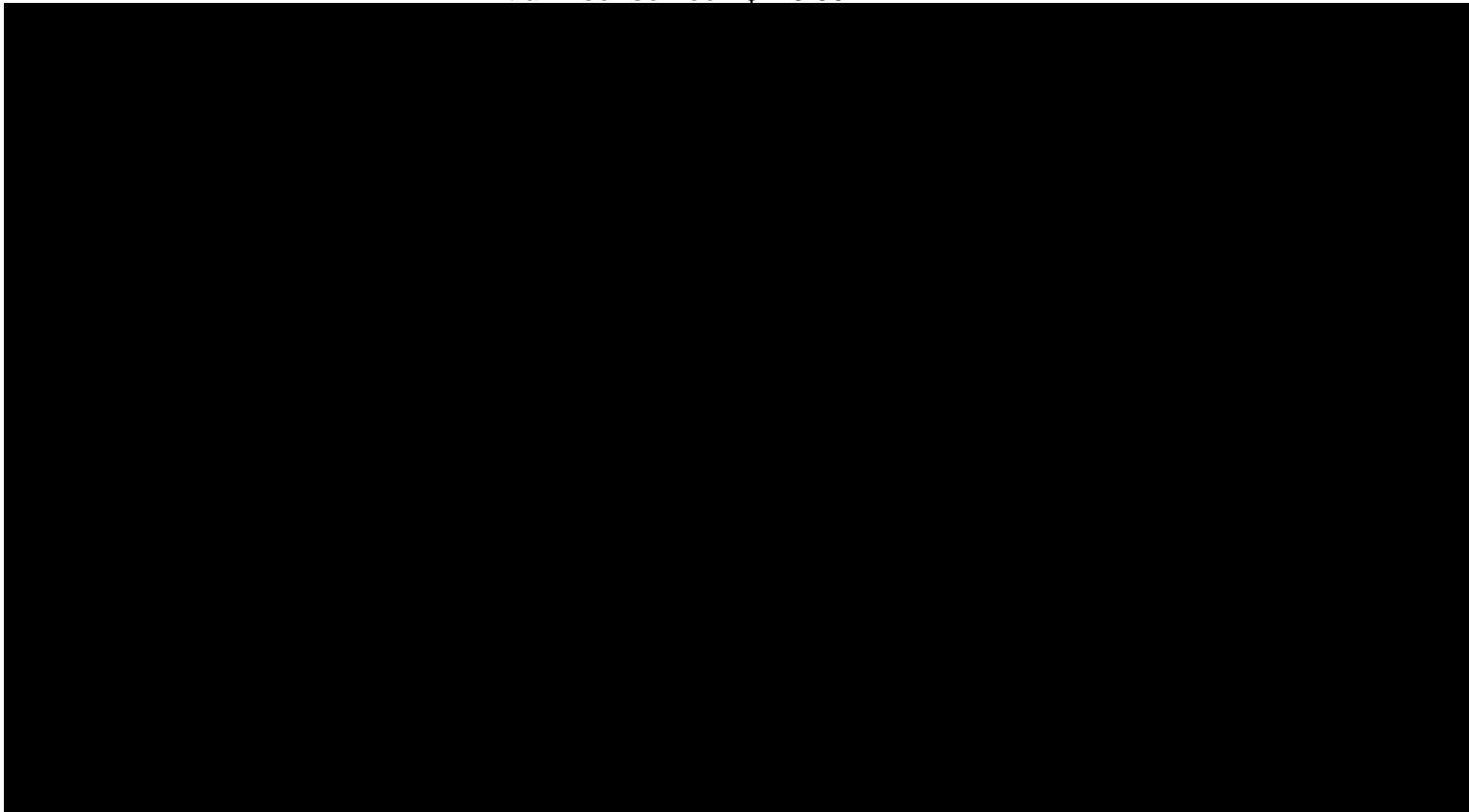
**The license issuance fee must be received within 35 days from the date of this letter or your application will be withdrawn, and you will need to reapply.**

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

### **ARIZONA MEDICAL BOARD PAYMENT CARD AUTHORIZATION**

**Payment for:** Milton Bird McColl, MD License #62712

**Initial License Fee: \$125.00**





## Arizona Medical Board

1740 W. Adams St, Suite 4000 • Phoenix, AZ 85007

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### LICENSE/RENEWAL CUSTOMER SATISFACTION SURVEY

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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	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/>
The staff was courteous	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/>
The staff provided accurate responses	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/>
The license/renewal application directions were clear and concise	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/>
The license was timely issued	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/>

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.

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**The Leland Stanford Junior University**  
to all to whom these Letters shall come Greeting

The Trustees and Faculty of the University, by virtue of the authority  
vested in them, have conferred on

**Milton Bird McColl**

who has satisfactorily pursued the Studies and passed the Examinations  
required therefor the Degree of

**Doctor of Medicine**

with all the Rights Privileges and Honors thereunto appertaining  
Given at Stanford University in the State of California on the Thirty-First Day of  
March in the Year One Thousand Nine Hundred and Eighty-Eight the Two Hundred-  
Twelfth Year of the Republic and the Ninety-Seventh Academic Year of the University.



*David Korn*

School of Medicine  
Founded as Cooper Medical College  
by Levi Cooper Lane

*Paul King*  
President of the University

*Wm Christopher*  
President of the Board of Trustees

ELECTRONIC  
SEAL  
VERIFIED



**Stanford**  
MEDICINE

Office of Medical  
Student Affairs  
*Registrar's Office*

Registrar's Office  
Office of Medical Student Affairs  
Stanford University School of Medicine  
1520 Page Mill Road, MC: 5263  
Palo Alto, CA 94304

December 4, 2020

RE: Milton McColl

To Whom It May Concern:

This letter is to explain why Milton McColl took 6 years to complete the M.D. degree at Stanford University School of Medicine.

Stanford University School of Medicine has a flexible curriculum, which is its major innovative approach to medical education. While traditional preclinical courses and clinical clerkships are required for graduation, the duration of study leading to the M.D. degree may vary from four to six years. The program offers flexibility and is designed so that students can pursue research or dual degrees during their M.D. program. Milton was also approved for personal leave of absences. Milton McColl was awarded the M.D. degree on March 31, 1988.

If I can be of further assistance, please do not hesitate to contact me at [celeste.nguyen@stanford.edu](mailto:celeste.nguyen@stanford.edu).

Sincerely,

Celeste Fowles Nguyen, EdD  
Registrar  
Stanford University School of Medicine





Verification of Postgraduate Medical Education	
Institution: <u>Santa Clara Valley Medical Center Program</u> Specialty: <u>Transitional Year</u> Address: <u>San Jose, CA</u>	Attention: <u>Program Director</u> Affiliated University: _____
<b>Verification For:</b>	Name: <u>Milton Bird McColl</u> DOB: <span style="background-color: black; color: black;">[REDACTED]</span> Individual's Name on Record (If different from above): _____
<b>Program Participation:</b> <b>Important:</b> Report Incomplete postgraduate years (PGY) separate from those that were successfully completed.  If the postgraduate year is currently in progress report the expected completion date in the "To" field.  Report Internships, Residencies and Fellowships separately.  Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.	PGY: <u>1</u> Specialty/Subspecialty: <u>Transitional Year</u> <input checked="" type="checkbox"/> Internship      From: <u>4/1988</u> To: <u>6/1988</u> <input type="checkbox"/> Residency      Successfully Completed?: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship      Accredited by: <input checked="" type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> Research <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these
	PGY: <u>1</u> Specialty/Subspecialty: <u>Transitional Year</u> <input checked="" type="checkbox"/> Internship      From: <u>1/1989</u> To: <u>11/1989</u> <input type="checkbox"/> Residency      Successfully Completed?: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Chief Residency      Accredited by: <input checked="" type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> Fellowship <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these <input type="checkbox"/> Research
	PGY: _____      Specialty/Subspecialty: _____ <input type="checkbox"/> Internship      From: _____      To: _____ <input type="checkbox"/> Residency      Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Chief Residency      Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> Fellowship <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these <input type="checkbox"/> Research
<b>Unusual Circumstances:</b> Check the correct response. Omitted responses require written explanation.  If necessary, you may continue your explanation on a separate sheet of paper.  <b>ELECTRONIC SEAL VERIFIED</b>	1. Did this individual ever take a leave of absence or break from his/her training? ..... <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 2. Was this individual ever placed on probation? ..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3. Was this individual ever disciplined or placed under investigation? ..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 4. Were any negative reports for behavioral reasons ever filed by instructors? ..... <span style="background-color: black; color: black;">[REDACTED]</span> 5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  Please explain any "Yes" response from above:  <u>Dr. McColl took a leave to play professional football however, he completed the 12 months of training.</u>
<b>Certification:</b>  Atfix your institutional seal in this space. If no seal is available, you must have this form notarized.	Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).  Name: <u>Jovanah Bonilla</u> Signature: <u>Jovanah Bonilla</u> Title: <u>GME Coordinator</u> Date of Signature: <u>12/22/2010</u> Tel: <u>408-885-5110</u> Fax: <u>408-885-6317</u> E-Mail: _____



Verification of Postgraduate Medical Education

Institution: Stanford Health Care-Sponsored Stanford University Program  
 Specialty: Family Medicine  
 Address: San Jose, CA

Attention: **Program Director**

Affiliated University: Stanford University SOM

Verification For:

Name: Milton Bird McColl

DOB: [REDACTED]

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

Program Participation: Important:

Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

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

PGY: 1

Specialty/Subspecialty: Family Medicine

- Internship  
 Residency  
 Chief Residency  
 Fellowship  
 Research

From: 7/1/2016 To: 6/30/2017

Successfully Completed?:  Yes  No  In Progress

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

PGY: 2

Specialty/Subspecialty: Family Medicine

- Internship  
 Residency  
 Chief Residency  
 Fellowship  
 Research

From: 7/1/2017 To: 6/3/2018

Successfully Completed?:  Yes  No  In Progress

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

PGY: 3

Specialty/Subspecialty: Family Medicine

- Internship  
 Residency  
 Chief Residency  
 Fellowship  
 Research

From: 7/1/2018 To: 6/30/2019

Successfully Completed?:  Yes  No  In Progress

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

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

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

Please explain any "Yes" response from above:

**ELECTRONIC SEAL VERIFIED**

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

Name: Grace Yu, MD Signature: [Signature]  
 Title: Program Director Date of Signature: 12/9/2020  
 Tel: (408) 283-7167 Fax: (408) 283-7168 E-Mail: grace.yu@stanford.edu







# NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)

## Endorsement of Certification

This document was prepared by  
National Board of Medical Examiners® (NBME®)

3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

**Recipient:** Arizona Medical Board  
1740 W Adams St, Suite 4000  
Phoenix, AZ 85007-2664

**Date:** 12/11/2020

**Examinee:** Milton Bird McColl

**Examinee ID:** 3-319-185-9

**Date of Birth:** [REDACTED]

**NBME Certification Date:** 12/01/1989

**Certificate#:** 319185

It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

### NBME PART I

Test Date	Pass/Fail	Score Scale	Total		Individual Subject Scores						
			Score	(Min.Pass)	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/12/1984	Pass	Three-Digit	445	(380)	450	460	505	445	410	455	450
		Two-Digit	77	(75)	77	78	81	77	75	78	77

### NBME PART II

Test Date	Pass/Fail	Score Scale	Total		Individual Subject Scores					
			Score	(Min.Pass)	Med	Surg	ObGyn	Prev	Peds	Psych
04/07/1987	Pass	Three-Digit	405	(290)	355	450	380	495	495	380
		Two-Digit	78	(75)	75	80	76	82	82	76

### NBME PART III

Test Date	Pass/Fail	Score Scale	Total	
			Score	(Min.Pass)
05/17/1989	Pass	Three-Digit	410	(290)
		Two-Digit	79	(75)

210 512 174



CC

RECEIVED

JUL 06 2021

AZ MEDICAL BOARD

### ARIZONA MEDICAL BOARD

1740 W Adams St, Suite 4000, Phoenix, AZ 85007  
Telephone: (480) 551-2700 - Website: www.azmd.gov

#### DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

\*\* Please Type or Print \*\*

PHYSICIAN NAME: Milton Bird McColl, MD

MD LICENSE #: 62712

SPECIALTY: FAMILY MEDICINE

Renewal Registration (\$150) (Renewal & fee must come together postmarked by 6/30)

- Confirm ALL locations below where you will be dispensing prescription drugs, devices and controlled substances. (For each location, place a check mark to verify address and schedule of drugs dispensed from each location are correct)
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.
- Blank form attached to add additional locations

#### PLEASE NOTE

A separate DEA license must be submitted for EACH location where controlled substances will be dispensed and must be kept current during the registration period

1837 E Baseline Road  
Tempe, AZ 85283

- Schedule II Drugs
- Schedule III Drugs
- Schedule IV Drugs
- Schedule V Drugs
- Prescription Only Drugs
- Prescription Devices

Dispensing location information correct     Copy of DEA attached     Remove this location

5771 W Eugie Avenue  
Glendale, AZ 85304

- Schedule II Drugs
- Schedule III Drugs
- Schedule IV Drugs
- Schedule V Drugs
- Prescription Only Drugs
- Prescription Devices

Dispensing location information correct     Copy of DEA attached     Remove this location

Physician's Signature: \_\_\_\_\_

*Milton Bird McColl*

Date: \_\_\_\_\_

5/21/21



ENTERED

*no envelope attached JM*

CC \$150.00



RECEIVED

JUL 06 2021

AZ MEDICAL BOARD

188/556 1:5 MCCOLL, MILTON B (MD)  
4751 N 15TH ST  
PHOENIX, AZ 85014-0000



10008100.2/002164-1/1-0

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[REDACTED]	01-31-2024	\$888
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	PRACTITIONER	02-11-2021
MCCOLL, MILTON B (MD) TEMPE HEALTH CENTER 1837 E BASELINE RD TEMPE, AZ 85283-0000		

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE  
UNITED STATES DEPARTMENT OF JUSTICE  
DRUG ENFORCEMENT ADMINISTRATION  
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE  
UNITED STATES DEPARTMENT OF JUSTICE  
DRUG ENFORCEMENT ADMINISTRATION  
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[REDACTED]	01-31-2024	\$888
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	PRACTITIONER	02-11-2021
MCCOLL, MILTON B (MD) TEMPE HEALTH CENTER 1837 E BASELINE RD TEMPE, AZ 85283-0000		

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Form DEA-223 (9/2016)



1:5  
187/656  
MCCOLL, MILTON B (MD)  
4751 N 15TH ST  
PHOENIX, AZ 85014-0000



10008100.2/002163-1/1-0

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[REDACTED]	01-31-2024	\$888
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	PRACTITIONER	02-11-2021
MCCOLL, MILTON B (MD) GLENDALE HEALTH CENTER 5771 W EUGIE AVE GLENDALE, AZ 85304-0000		

**CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE**  
 UNITED STATES DEPARTMENT OF JUSTICE  
 DRUG ENFORCEMENT ADMINISTRATION  
 WASHINGTON D.C. 20537

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**CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE**  
 UNITED STATES DEPARTMENT OF JUSTICE  
 DRUG ENFORCEMENT ADMINISTRATION  
 WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[REDACTED]	01-31-2024	\$888
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	PRACTITIONER	02-11-2021
MCCOLL, MILTON B (MD) GLENDALE HEALTH CENTER 5771 W EUGIE AVE GLENDALE, AZ 85304-0000		

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Form DEA-223 (9/2016)





# ARIZONA MEDICAL BOARD

## DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

1740 W. Adams St. Ste. 4000  
Phoenix, AZ 85007-2664  
[www.azmd.gov](http://www.azmd.gov)

2001

RECEIVED  
MAR 12 2021

AZ MEDICAL BOARD

- Initial Registration Fee \$200 (per physician)**
- Renewal Registration Fee \$150 (per physician)**

First Name:  Initial:  Last Name:   
 License Number:  Specialty:

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE

A *separate* DEA license must be submitted for *EACH* location where controlled substances will be dispensed and must be kept current during the registration period.

**PRIMARY PRACTICE LOCATION:**

DEA# for this location: [REDACTED]

Address:  City:  State:  Zip:   
 Phone:  Fax:  Email: [REDACTED]

- Schedule II Drugs
- Schedule III Drugs
- Schedule IV Drugs
- Schedule V Drugs
- Prescription-Only Drugs
- Prescription Devices
- Nubain

ENTERED

**ADDITIONAL PRACTICE LOCATION:**

DEA# for this location: [REDACTED]

Address:  City:  State:  Zip:   
 Phone:  Fax:  Email: [REDACTED]

- Schedule II Drugs
- Schedule III Drugs
- Schedule IV Drugs
- Schedule V Drugs
- Prescription-Only Drugs
- Prescription Devices
- Nubain

I am including a second page listing additional locations

Physician Signature:  Date:

Make checks or money orders payable to Arizona Medical Board.  
If you wish to pay by payment card, please complete the attached Payment Card Authorization Form



187/656  
 1:5  
 MCCOLL, MILTON B (MD)  
 4751 N 15TH ST  
 PHOENIX, AZ 85014-0000



DEA REGISTRATION [REDACTED]	THIS REGISTRATION EXPIRES	FEE PAID
	01-31-2024	\$888
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	PRACTITIONER	02-11-2021
MCCOLL, MILTON B (MD) GLENDALE HEALTH CENTER 5771 W EUGIE AVE GLENDALE, AZ 85304-0000		

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 WASHINGTON D.C. 20537

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2,2N, 3,3N,4,5	PRACTITIONER	02-11-2021
MCCOLL, MILTON B (MD) GLENDALE HEALTH CENTER 5771 W EUGIE AVE GLENDALE, AZ 85304-0000		

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188/656  
 1:5  
 MCCOLL, MILTON B (MD)  
 4751 N 15TH ST  
 PHOENIX, AZ 85014-0000



10008100.2/002164-1/1-0

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[REDACTED]	01-31-2024	\$888
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	PRACTITIONER	02-11-2021
MCCOLL, MILTON B (MD) TEMPE HEALTH CENTER 1837 E BASELINE RD TEMPE, AZ 85283-0000		

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE  
 UNITED STATES DEPARTMENT OF JUSTICE  
 DRUG ENFORCEMENT ADMINISTRATION  
 WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

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Form DEA-223 (9/2016)



Planned Parenthood Arizona, Inc.

4751 N 15<sup>th</sup> Street  
Phoenix, AZ 85014-3707

PHOENIX AZ 852

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US POSTAGE

\$000.51<sup>0</sup>



ZIP 85014  
041M11292474

Arizona Medical Board  
1740 W. Adams St., Ste 4000  
Phoenix, AZ 85007-2664

85007-266400



**AMB Physician Renewal Confirmation (Step 8 of 11)**

7/25/2021

**Dr. Milton Bird McColl**

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 "YES"**, 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

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

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

2) This question has been deleted

***Citizenship Status***

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

***Specialties***

	<u>Specialty</u>	<u>Certified?</u>	<u>Practicing?</u>	<u>Date Certified</u>	<u>Expiration Date</u>
Primary Specialty	Family Medicine	Yes	Yes	07/01/2019	

Specialty 2

Specialty 3

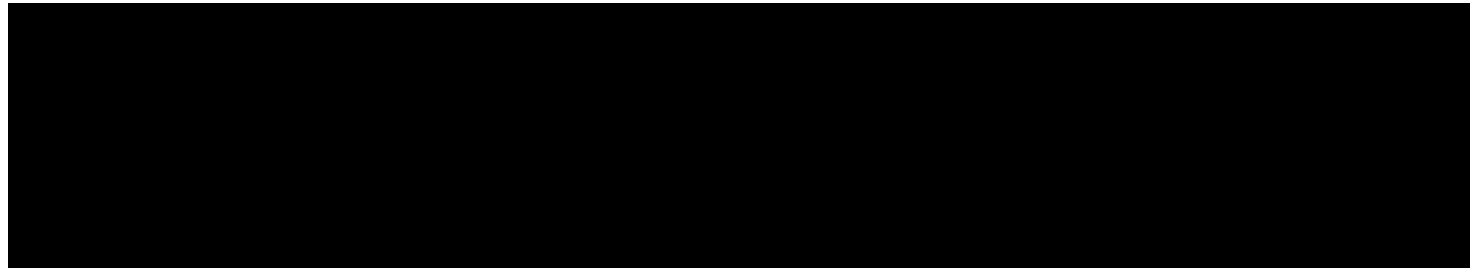
Specialty 4

***Practice Address***

Planned Parenthood  
1837 E Baseline Rd  
Tempe AZ, 85283  
Phone (602) 277 7526  
Fax:

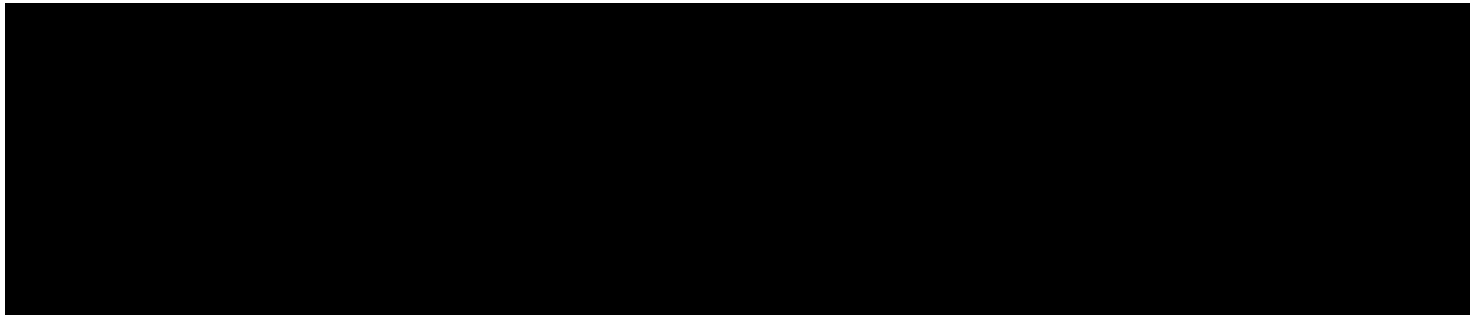
You are required to enter a valid address, if you have one.

***Home Address***



***Mailing Address***

1837 E Baseline Rd  
Tempe AZ, 85283



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

<b>Yes</b>	<b>No</b>
------------	-----------

***MD Training Unit  
Complete***

You may wish to print this Page for your records.

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