



64706

# ARIZONA MEDICAL BOARD

CK # 1894

## MD UNIVERSAL RECOGNITION LICENSE APPLICATION

\$ 550.00

1740 W. Adams St. Ste. 4000  
Phoenix, AZ 85007-2664  
www.azmd.gov

MD-21-2940

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

### Personal Information

1. First Name:

Middle Name:

Last Name:

Other Names Used:

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AZ MEDICAL BOARD

2. Social Security Number:

3. Date of Birth:  City of Birth:

State of Birth:  Country of Birth:

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

### Address Information

**Practice Address:** This is the practice/principal place of your business. The address and phone number provided will appear in the Medical Directory and on the Board's website. Every physician must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public upon request. If you want your home address to be listed as your practice address on the Board's website, include the address in the practice address field.

4. Practice Name:

Address:  City:  State:  Zip:

Phone:  Fax:  \*Practice address not required for licensure

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

5. Home Address:  City:  State:  Zip:

Phone:  Mobile:

Primary Email Address:

**Mailing Address:** If no address is provided, all Board correspondence will be sent to your practice address. Please note - Your fingerprint packet will be sent to your mailing address.

6. Mailing Address:  City:  State:  Zip:

Same as Practice Address  Same as Home Address

In addition to your primary e-mail address provided on page one of this application, please indicate if you would like to designate/authorize an individual or prospective employer, beside yourself, to receive status updates on your application.

Please note: If a substantive review/investigation is required during the application process, the applicant will be required to provide additional authorization, in writing, for the third party to receive status updates concerning the substantive review.

Name  Phone#  E-mail

Name  Phone#  E-mail

**7. Qualification for Universal Recognition License**

Attach proof of residency or Military Form 2058. A list of acceptable documentation establishing residency in Arizona can be found on the application checklist.

I have established residence in the state of Arizona.

I am a person married to an active duty member of the armed forces of the United States who is stationed to a military installation located in the state of Arizona.

**8. Other State Medical License(s)**

Please list all states in which you have applied for or have been granted a license to practice medicine, including license number, date issued and current status of the license. If more than 10, attach a separate listing. If a license is pending or was not issued, so state.

State Board:	License No.:	Date Issued:	License Status:
Illinois	036-051083	07/31/2020	Active

First Name:  Last Name:

**9. Citizenship Attestation**

**Proof of Citizenship:** Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States, Pursuant to A.R.S. § 41-1080 and A.A.C. R4-16-201(C)(1) require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona.

<input checked="" type="checkbox"/> I am a U.S. Citizen or U.S. National.	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (Also review the application checklist).
<input type="checkbox"/> I am NOT a U.S. Citizen or U.S. National.	If this box is checked, please submit documentation as stated on the Statement of Citizenship form (Also review the application checklist).

**10. Questionnaire**

- Are you currently under investigation by any medical board?  
*(Pursuant to A.R.S. § 32-4302(A)(7) If an applicant has any complaints, allegations or investigations pending the Board will suspend the application process and may not issue or deny a license to the applicant until the complaint, allegation or investigation is resolved.)*
Yes  No

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- Have you ever had a medical license in any state or country disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation during an investigation, or entered into a consent agreement or stipulation?
 Yes  No

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- Have you ever been convicted of a crime? If yes, provide court records of all convictions including all applicable records of set asides or expungements. *(Do not include juvenile convictions.)*
Yes  No

**NOTE:** In the event that the response to any of the questions is "Yes", you must file an explanation and submit photocopies of any corresponding documents. Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

**11. Training Unit Attestation**

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

Initials

*I am aware that I am responsible for knowing and adhering to the laws governing the practice of medicine in Arizona. I declare under penalty of perjury that I have read and completed all four pages of the training unit provided with this application and available on the Board's website.*

Full Name:

Signature:

Date:

Pursuant to A.R.S. § 32-1403.01(A) The board shall make available to the public a profile of each licensee. The board shall make this information available through an internet website and, if requested, in writing.

Medical School Name:

Medical School Location:

Graduation Date:

Post Graduate Training Information

Institution:  City:  State:

Dates of Attendance: Beginning:  Ending:

Type of Program:

Specialty:

Institution:  City:  State:

Dates of Attendance: Beginning:  Ending:

Type of Program:

Specialty:

Institution:  City:  State:

Dates of Attendance: Beginning:  Ending:

Type of Program:

Specialty:

Area of Interest

Indicate your area of interest/specialty:

First Name:  Last Name:



Arizona Medical Board Universal Recognition Application Attestation

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

Failure to report any adverse actions to the Board during the licensure process may result in denial or revocation of your license.

Signature of Applicant:

Murray Pelta

Date:

07/24/2021

Notarization

Subscribed and sworn in front of me by Murray Pelta, personally appearing on this date July 24<sup>th</sup>, 2021.  
Applicant Name

Matthew J. Michalak  
Notary Public's Signature

(Personalized Seal)



First Name:

Murray

Last Name:

Pelta

# CERTIFICATION OF IDENTIFICATION

Certification by Notary Public is Required

Applicant Full Legal Name: Pelta Murray  
Last First Middle

**Notary - Please complete the section below and attach a photocopy of the Birth Certificate or Passport.**

State of Illinois County of Lake

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 24<sup>th</sup>, of (Month) July, (Year) 2021.

Notary Public Signature: Matthew J Michalak

Commission Expiration Date\* (Month) September / (Day) 10 / (Year) 2022

**\*The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Applicant's Signature: [Signature]

Notary Stamp Here



Please complete and mail or email the notarized Certificate of Identification form and a photocopy of the Birth Certificate or Passport presented to the Notary to:

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

[LicensingReport@azmd.gov](mailto:LicensingReport@azmd.gov)

Pursuant to A.R.S. § 32-1403.01(A) The board shall make available to the public a profile of each licensee. The board shall make this information available through an internet website and, if requested, in writing.

Medical School Name:

Medical School Location:  Graduation Date:

Post Graduate Training Information

Institution:  City:  State:

Dates of Attendance: Beginning:  Ending:

Type of Program:

Specialty:

Institution:  City:  State:

Dates of Attendance: Beginning:  Ending:

Type of Program:

Specialty:

Institution:  City:  State:

Dates of Attendance: Beginning:  Ending:

Type of Program:

Specialty:

Area of Interest

Indicate your area of interest/specialty:

First Name:  Last Name:



Sharon Mauk <sharon.mauk@azmd.gov>

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## Arizona Medical Board

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**Murray Pelta** [REDACTED]  
To: Sharon Mauk <sharon.mauk@azmd.gov>

Wed, Jan 19, 2022 at 12:51 PM

Thank you for explaining the status of my application. Attached is edited page 4 with my area of interest and you have corrected my e mail to [REDACTED] I am reaching out to Betty at x 2767 to learn the status of my fing

Sincerely,

Murray Pelta, MD

[Quoted text hidden]

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## Arizona Medical Board

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

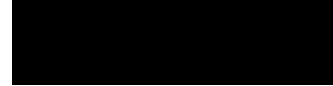
Telephone: 480-551-2700 • Fax: 480-551-2704

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

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August 10, 2021

Murray Pelta, M.D.



Email Address: 

Dear Dr. Pelta:

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. **Please complete page 4 of the MD Universal Application by entering your Area of Interest. (attached) Your Area of Interest is the area of medicine in which you intend to practice.**

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

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, 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.

Thank you for submitting an application to practice medicine in Arizona. Please contact our office with any questions.

Sincerely,

Sharon Mauk  
Senior Licensing Coordinator  
Arizona Medical Board  
Phone Number 480-551-2711  
Fax Number 480-551-2704  
Email [Sharon.Mauk@azmd.gov](mailto:Sharon.Mauk@azmd.gov)