

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2
3 In the Matter of

4 **JOHN C. MORGAN, M.D.**

5 Holder of License No. 25871
6 For the Practice of Allopathic Medicine
7 In the State of Arizona.

Case No. **NO. 08A-25871-MDX**

**FINDINGS OF FACT, CONCLUSIONS OF
LAW AND ORDER FOR LETTERS OF
REPRIMAND**

8 On August 6, 2008 this matter came before the Arizona Medical Board ("Board") for
9 oral argument and consideration of the Administrative Law Judge (ALJ) Diane Mihalsky's
10 proposed Findings of Fact and Conclusions of Law and Recommended Order. John C.
11 Morgan, M.D. ("Respondent") was notified of the Board's intent to consider this matter on
12 the aforementioned date at the Board's public meeting. Respondent was represented by
13 his attorney, Michael Golder. Philip Overcash represented the State. Chris Munns,
14 Assistant Attorney General with the Solicitor General's Division of the Attorney General's
15 Office, was present and available to provide independent legal advice to the Board.
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17 The Board, having considered the ALJ's report and the entire record in this matter
18 hereby issues the following Findings of Fact, Conclusion of Law and Order.
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20 **FINDINGS OF FACT**

21 **PROCEDURE**

- 22 1. The Arizona Medical Board ("the Board") is the duly constituted authority for the
23 regulation and control of the practice of allopathic medicine in the State of Arizona.
- 24 2. The Board issued to Respondent John C. Morgan, MD License No. 25871 for
25 the practice of allopathic medicine in the State of Arizona.

1 8. Ms. Hinckley, who at that time was the Board's Senior Medical Investigator, had
2 subpoenas issued for M.C.'s medical records from Simply the Best, John C. Lincoln
3 Hospital, and Dr. Morgan's practice, House Call Family Physician.

4 9. Dr. Morgan also provided M.C.'s records with his responses to the complaint.

5 10. Dr. Sems reviewed M.C.'s records. Dr. Sems graduated from the University of
6 Nebraska Medical center. She is a rheumatologist.

7 11. Dr. Sems last treated a patient in August 2005, when she was asked to consult
8 by an attending physician. Since rheumatic diseases are systemic, she must be familiar
9 with all body systems and side effects of drugs. Although she is not a primary care
10 provider, she may function as a primary care provider by virtue of her training in internal
11 medicine and treatment of systemic rheumatic diseases.
12

13 12. MC was an 87-year-old woman who had lived at Simply the Best, a group
14 home.

15 13. Dr. Morgan had cared for M.C. between November 8, 2004 and no later than
16 October 22, 2005.

17 14. Included among M.C.'s records was a form from House Call Family Physician
18 for Patient Medical Information dated July 7, 2005. House Call Family Physician was Dr.
19 Morgan's practice group and the form shows a facsimile header of "07/07/2005 05:03 . . .
20 John Morgan MD Page 03."¹

21 15. On the July 7, 2005 Patient Medical Information, M.C.'s daughter disclosed that
22 M.C. had a history of dementia, Alzheimer's, hypertension, and chronic renal failure
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25 ¹ Ex. 2 at AMB/JM 0073.

1 ("CRF"). She took 81 mg of aspirin daily. Other records indicated that M.C. suffered from
2 osteoarthritis and Gastroesophageal Reflux Disease ("GERD").

3 16. M.C. was taking 150 mg Ranitidine for her GERD.

4 17. On November 15, 2005, M.C. vomited blood and had melena, which means
5 dark stools usually caused by the presence of blood.

6 18. As a result of these symptoms, M.C. was admitted to John C. Lincoln Hospital
7 on November 16, 2005, where she was diagnosed with anemia secondary to a GI bleed,
8 given blood transfusions, and discharged on November 19, 2005.

9 19. Among the discharge plans were to discontinue the NSAIDs that M.C. had
10 been prescribed. After she was discharged, M.C. never regained her prior level of health
11 and died on December 23, 2005.

12
13 **Evidence of Dr. Morgan's Possible Statutory Violations**

14 20. Dr. Sems testified that Naproxen, or Aleve, is a Non-Steroidal Anti-
15 Inflammatory Drug, or NSAID. The dangers of prescribing an NSAID like Aleve for pain
16 relief is that its common side effects include GI bleeding and heartburn.

17 21. Dr. Sems testified that NSAIDs also may decrease renal function. Decreased
18 renal function is shown by an increase in Creatinine.

19 22. Dr. Sems testified that, before a physician prescribes Aleve for pain relief, he
20 should take into account the patient's history of CRF and use caution. He either should
21 not prescribe the NSAID, should prescribe a reduced dose and monitor the patient's
22 Creatinine level, or should prescribe the NSAID for only a short time.

23 23. Laboratory results for M.C. dated 10/21/04 showed a Creatinine level of 1.9,
24 which was elevated according to the laboratory's reference range. Dr. Sems testified that
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1 this result showed M.C.'s decreased renal function. Typically, Creatinine is between .08
2 and 1.5 in healthy people.

3 24. Dr. Sems testified that the physician also should not prescribe an NSAID to a
4 patient diagnosed with CRF without also prescribing a prophylactic, such as a proton
5 pump inhibitor drug, to reduce acid production in the stomach and protect against ulcers
6 and GI bleed.

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8 25. On July 18, 2005, Dr. Morgan diagnosed M.C. with right 5th metatarsal strain
9 and prescribed Aleve to treat M.C.'s pain and inflammation.

10 26. A Verbal Order Form from Simply the Best for M.C. dated 7/18/05 showed that
11 Dr. Morgan prescribed 2 tabs of Aleve b.i.d. for 10 days.² Dr. Morgan signed the Verbal
12 Order Form on July 18, 2005 to approve it.

13 27. The Verbal Order Form also shows that M.C.'s prescriptions for Albuterol and
14 Tylenol were discontinued.

15 28. Dr. Sems testified that Albuterol and Tylenol are not proton pump inhibitors.

16 29. The Medication Administration Record for M.C. shows that, between 7/18/05
17 and 7/28/05, Aleve was administered to her at 8:00 a.m. and 8:00 p.m.

18 30. Dr. Sems pointed out that the Medication Record for M.C. shows that Aleve
19 was administered beginning on 7/18/05 and beginning on 9/22/05.³ Dr. Sems pointed out
20 that "1 x 14 days" was written above "Aleve ii b.i.d." For all the other 11 drugs on the
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23 ² See Ex. 2 at AMB/JM 0581.

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25 ³ See Ex. 2 at AMB/JM 0080.

1 Medication Record, the dosage was listed under the drug. No duration was included for
2 any of the drugs listed on the Medication Records.⁴

3 31. The Verbal Order Form for Simply the Best dated 9/22/05 noted an order for
4 "Alive ii take p.o. b.i.d." with no duration shown.⁵ Dr. Morgan signed the Verbal Order Form
5 on 9/22/05.

6 32. Dr. Morgan prepared Progress Note for M.C. dated 9/22/05 showed the plan
7 "Aleve ii bid daily x 14 days."⁶ Dr. Sems testified that this progress note was not consistent
8 with the verbal order.

9 33. The Medication Administration Record for September for M.C. showed that,
10 between 9/22/05 at 8 p.m. through the end of September 2005, she received two tablets
11 p.o. b.i.d. of Aleve.⁷

12 34. The Medication Administrative Record for October showed the M.C. continued
13 to receive Aleve at 8 a.m. and 8 p.m. until 10/22/05.⁸

14 35. On October 13, 2005, Dr. Morgan was faxed an order to evaluate and admit
15 MC to Vitas Hospice services. Dr. Morgan stated in his licensee response that he had no
16 further calls on MC after September 22, 2005.
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20 ⁴ See Ex. 2 at AMB/JM 0079, 0080.

21 ⁵ See Ex. 2 at AMB/JM 0580.

22 ⁶ See Ex. 2 at AMB/JM 0068.

23 ⁷ See Ex. 2 at AMB/JM 0506.

24 ⁸ See Ex. 2 at AMB/JM 0503.
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1 36. On 10/23/05, Dr. Featherston assumed M.C.'s care and prescribed two tabs of
2 Aleve three times a day. Dr. Featherston also prescribed Prilosec, a proton pump
3 inhibitor.

4 37. The Medication Administration Record for October also showed that, on
5 10/23/05, M.C. began receiving Aleve three times at day, at 8 a.m., 12 p.m., and 8 p.m.⁹

6 38. Dr. Sems testified that Dr. Morgan deviated from the standard of care by not
7 taking into account M.C.'s risks for potential GI bleed, including her age, her history of
8 GERD, her low dose Aspirin therapy and poor general health, when he prescribed the
9 Aleve on September 22, 2005 without either initiating concomitant prophylactic measures
10 or including a stop date.

11 39. Dr. Sems testified that she could not find any indication in M.C.'s medical
12 records that Dr. Morgan had considered her CRF when he prescribed Aleve on September
13 22, 2005. In Dr. Morgan's May 18, 2006 response to Dr. Sems' initial report, he stated
14 that, "[b]ased on clinical examination and information provided by the caregiver and to a
15 very lesser extent by the patient, I was not made aware of CRF" and that "[M.C.] did not
16 present with any history or physical findings of CRF."¹⁰

17 40. Dr. Morgan's response continued:

18 On September 22, 2005, during our visit to see [M.C., M.C.'s daughter] reported
19 that the patient continued to have pain and requested Aleve because [M.C.] did well and
20 presented no problems, bleeding or otherwise. At that point I did order Aleve 2 BID X 14
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23
24 ⁹ See *id*

25 ¹⁰ Ex. 4 at AMB/JM 0089.

1 at the caregiver's insistence. (Exhibit 4 [his 9/22/05 Progress Note].) To my regret, I did
2 sign an order with the omission of the X 14 on the order record at the home. I noted X14
3 days above the previous Aleve order on the medication list. . . . I was not given the
4 opportunity for review or follow up on my next visit. [M.C.] was already being seen by a
5 Vitas physician.

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8 In retrospect, had I been aware of the CRF, I would have proceeded as indicated in
9 my previous letter with this less than therapeutic dose anyway based on [M.C.'s
10 daughter's] insistence that Aleve had worked well for [M.C.] and that she wanted to be
11 given another dose. However, I would have certainly considered adding a proton pump
12 inhibitor, although giving this does not stop GI bleeding as we all know.¹¹

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14 41. Dr. Sems testified that Dr. Morgan's response indicated that he did not take
15 into account M.C.'s CRF when he prescribed Aleve to M.C., even though it was mentioned
16 on the House Call Family Physician Patient Medical Information that M.C.'s daughter had
17 filled out.

18 42. Dr. Sems testified that the records were inconsistent. It also appeared that the
19 duration for the Aleve had been added after the fact to the Medical Record. Based on her
20 review, she concluded that Dr. Morgan had altered the medical records.

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22 43. On October 31, 2006, Dr. Morgan responded to the Board's allegation of
23 altered medical records. He stated, "I agree, [the Medication Record for M.C.] does look

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25 ¹¹ Ex. 4 at AMB/JM 0090.

1 altered, but it is not. I never alter my notes unless it is done immediately after the notes
2 are written, and then, 'a mark of error' is noted on the chart." ¹²

3 44. Dr. Sems admitted that some of the drugs that had been prescribed to M.C. for
4 her hypertension would have had some healthy effect on her kidney function. CRF is an
5 incurable disease that will kill the patient, if she does not undergo dialysis or die of another
6 cause.

7 45. Dr. Sems admitted that many drugs that had been prescribed to M.C. to treat
8 her various physical and psychiatric conditions could have had potentially severe side
9 effects.

10 46. The November 19, 2005 Discharge Summary for D.C. noted that "[t]he patient
11 is a DNR/DNI as per her daughters who are the Power of Attorneys and per her wishes
12 she did not want an invasive or extensive diagnostic or therapeutic procedures. Since an
13 EGD was deferred the patient was placed on PPI, Proton pump inhibitor, IV twice a day by
14 gastroenterology."

15 47. Dr. Sems testified that an EGD would have involved a scope from the stomach
16 to the duodenum to identify the site of the bleeding. Since the EGD had been deferred, it
17 is possible that the site of the bleeding could have been D.C.'s esophagus, which would
18 have been unrelated to the administration of NSAIDs.

19 48. Dr. Sems testified that a proton pump inhibitor increases the ph level in the
20 stomach and makes it less acidic. The renitidine that had been prescribed for D.C.'s
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22 ¹² Ex. 5 at AMB/JM 0111.
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1 GERD would have increased the ph level of her stomach. But it would not have been as
2 effective as a proton pump inhibitor.

3 49. Dr. Sems testified that she had not seen M.C.'s death certificate and did not
4 know whether an autopsy had been performed. She did not know the cause of M.C.'s
5 death.

6 50. Dr. Sems noted that the John C. Lincoln Hospital laboratory results for M.C.'s
7 Creatinine level were 1.4. This level was lower than when she was admitted to Simply the
8 Best long-term care facility. M.C.'s Creatinine level may have indicated improved renal
9 function. Dr. Sems testified that 1.4 is at the upper level of normal.

10 51. Dr. Sems testified that she did not know the specific diagnosis of M.C.'s kidney
11 disease. She did not know for sure that Dr. Morgan's prescription of an NSAID adversely
12 affected M.C.'s kidney.

13 52. Dr. Sems testified that the Medication Administration Record for M.C. for July
14 2005, which showed "Aleve ii poBid x 10 days" beginning on July 18, 2005, did not deviate
15 from the standard of care because it showed an acceptable duration.

16 53. Dr. Sems testified that the Progress Note for 9/22/05, which showed a
17 prescription to M.C. of "Aleve ii Bid daily x 14 days" also was within the standard of care.
18 However, a prescription of Aleve for more than 14 days without the concomitant
19 prescription of a prophylactic would have deviated from the standard.

20 54. Dr. Sems admitted that the progress note was a contemporaneous record that
21 could have been included in the chart. Dr. Sems testified, however, that she believed that
22 the 9/22/05 Progress Note was not included in the records from Simply the Best but may
23 have been a record that Dr. Morgan sent in.
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1 to be placed on probation for five years.¹³ Among the terms of his probation, Dr. Morgan
2 agreed to have a third-party female chaperone present whenever he interacted with
3 female patients. The third-party female chaperone was required to be "a licensed allied
4 healthcare provider (i.e., physician assistant, registered nurse, licensed practical nurse)
5 employed by [Dr. Morgan], hospital or clinic"

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7 62. On March 1, 2007, Dr. Morgan sent an e-mail to Board staff, identifying the
8 chaperone required by the Consent Agreement as his female office assistant, Carolyn
9 Hughes. On March 26, 2007, Dr. Morgan provided a certificate issued by the American
10 Association of Medical Assistants, Inc. for Ms. Hughes.¹⁴ The certificate showed that Ms.
11 Hughes was a certified medical assistant.

12 63. Ms. Dana testified at the hearing that a certified medical assistant is not
13 considered to be a licensed allied healthcare provider.

14 64. Ms. Dana admitted that there was no evidence that Dr. Morgan had violated
15 any other term of the Consent Agreement, had committed any other untoward conduct, or
16 had harmed a patient or member of the public. He had not lied about the identity of his
17 chaperone.

18 65. The Board had admitted into evidence transcripts of telephone conversations
19 between Dr. Morgan and Ms. Dana on March 26 and 27, 2007.¹⁵ During the second
20 conversation, Dr. Morgan informed Ms. Dana that he had run an advertisement for an RN
21 for two months before he hired his medical assistant and had received no response. Dr.
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24 ¹³ Ex. 8 (AMB/JM 0835-0850).

25 ¹⁴ Ex. 11 at AMB/JM 0976.

1 Morgan had never used an RN during the 30 years of his practice and did not believe that
2 an RN would respond to an advertisement “that described her job position as being my
3 babysitter.”¹⁶

4 66. Ms. Hughes had signed all of Dr. Morgan’s Progress Notes for patients seen
5 between February 12, 2007 and March 27, 2007.¹⁷

6 **APPLICABLE LAW**

7 1. A.R.S. § 32-1451(M) provides in relevant part:

8 Any doctor of medicine who after a formal hearing is found by the board to be guilty
9 of unprofessional conduct . . . is subject to censure, probation as provided in this section,
10 suspension of license or revocation of license or any combination of these, including a
11 stay of action, and for a period of time or permanently and under conditions as the board
12 deems appropriate for the protection of the public health and safety and just in the
13 circumstance. The board may charge the costs of formal hearings to the licensee who it
14 finds in violation of this chapter.
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17 2. A.R.S. § 32-1401(27) defines “unprofessional conduct” to include:

18 (e) Failing or refusing to maintain adequate records on a patient.
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22 ¹⁵ Ex. 12 (AMB/JM 0052-0862).

23 ¹⁶ Ex. 12 at AMB/JM 0856.

24 ¹⁷ Ex. 13 (AMB/JM 0919-0974).
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1 (q) Any conduct or practice that is or might be harmful or dangerous to the
2 health of the patient or the public.

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5 (r) Violating a formal order, probation, consent agreement or stipulation issued
6 or entered into by the board or its executive director under the provisions of this chapter.

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10 (t) Knowingly making any false or fraudulent statement, written or oral, in
11 connection with the practice of medicine

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14 (jj) Knowingly making a false or misleading statement to the board or on a form
15 required by the board or in a written correspondence, including attachments, with the
16 board.

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18 3. A.A.C. R4-16-603 provides in relevant part as follows:

19 A physician commits an act of unprofessional conduct when the physician violates
20 one or more subparagraphs of A.R.S. § 32-1401(27). These statutory violations are
21 referenced under the categories that follow:

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1 2. “False Representations” include those actions or omissions that violate
2 A.R.S. § 32-1401(27)(m), (t), (v), (aa), (bb), (jj), (mm), or (qq).

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4 a. A one-time offense may result in either a Letter of Reprimand or a Decree of
5 Censure, the latter penalty for serious violations. Either may include probation.

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7
8 10. “Medical Records Issues” includes those actions or omissions that violate
9 A.R.S. § 32-1401(27)(e), or (r).

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11 a. A one-time occurrence of a minor nature that does not depart from the
12 standard of care may be issued an Advisory Letter.

13
14 b. Repetitive, egregious, or non-remediable offenses may result in a minimum
15 penalty of Letter of Reprimand.

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17 11. “Violations of Board Orders” includes those actions or omissions that violate
18 A.R.S. § 32-1401(27)(r), or (nn).

19
20 a. A one-time offense may result in a minimum penalty of a letter of Reprimand.

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1 18. "Departures from the Standard of Care" includes those actions or omissions
2 that violate A.R.S. § 32-1407(27)(l), (q), or (ll).

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4 a. Technical Errors:

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6 i. When there has been a technical error, the Board may consider the following
7 factors:

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9 (1) Whether the procedure was otherwise performed within the standard of care;

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11 (2) Whether the complication that occurred is a complication that is documented
12 to occur when the procedure is otherwise competently performed;

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14 (3) Whether the complication was recognized in a timely fashion and then
15 treated appropriately;

16
17 (4) Whether the patient and/or the patient's family was informed of the
18 complication/ error in a timely fashion; and

19
20 (5) Whether the proper informed consent was obtained from the patient prior to
21 the procedure or surgery.
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1 doubt, is still sufficient to incline a fair and impartial mind to one side of the issue rather
2 than the other.”²¹

3 3. The Board has borne its burden to establish that Dr. Morgan did not comply with
4 the terms of the Consent Agreement by having a licensed allied health care provider
5 chaperone his patients’ office visits. This term of the Board’s order was not meaningless;
6 it was entitled to require a chaperone who was licensed by a state agency. Dr. Morgan did
7 not inform the Board of his difficulty in hiring a licensed health care provider, did not ask
8 the Board to modify the Consent Agreement, and, in any event, has not established
9 impossibility of performance of this term of the Consent Agreement.
10

11 4. The Board therefore has established that, by failing to hire a licensed allied
12 health care provider, Dr. Morgan committed unprofessional conduct as defined by A.R.S. §
13 32-1401(27)(r). Under A.A.C. R4-16-603(11)(a), a letter of reprimand is an appropriate
14 penalty.

15 5. With respect to the issue of whether Dr. Morgan prescribed Aleve to M.C.
16 without taking into account her CRF, his response to the Board’s investigation
17 acknowledged that he was unaware of this diagnosis. But no unprofessional conduct
18 would have occurred if he had also set a duration for the prescription, as he did on
19 7/18/05.
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21 6. The 9/22/05 Verbal Order form included no duration. Although the Medication
22 Record shows “1 x 14 days” for the Aleve prescribed on 7/18/05 and 9/22/05, no duration
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25 ²¹ BLACK’S LAW DICTIONARY at page 1220 (8th ed. 1999).

1 is shown for any other medication. The 7/18/95 Verbal Order form shows that the Aleve
2 that Dr. Morgan prescribed on that date had a 10-day duration.

3 7. Moreover, the Medication Administration Record shows that M.C. was
4 administered Aleve from 9/22/05, when Dr. Morgan signed the Verbal Order form for this
5 amount that shows no duration, until 10/23/05, when Dr. Featherston assumed M.C.'s care
6 and prescribed Aleve three times a day with a proton pump inhibitor. It does not appear
7 that the nursing staff at Simply the Best was aware of Dr. Morgan's 9/22/05 Progress
8 Note.

9
10 8. The Board therefore has established that Dr. Morgan prescribed Aleve to M.C.
11 without specifying a specific duration or prescribing a prophylactic. The Board has
12 therefore established that Dr. Morgan committed unprofessional conduct as defined by
13 A.R.S. § 32-1401(27)(q).

14 9. It is a closer question on whether Dr. Morgan violated A.R.S. § 32-1401(27)(t) by
15 altering a patient record and A.R.S. § 32-1401(27)(jj) by failing to admit the alteration to
16 the Board. Given the inconsistencies noted by Dr. Sems and the failure of Simply the Best
17 Staff to follow the altered record, the Board has also established that Dr. Morgan altered
18 the Medication Record by adding "1 x 14 days" to it at some point after he signed the
19 9/22/05 Verbal Order.

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21 10. With respect to the appropriate penalty, Dr. Morgan's alteration of patient
22 records and refusal to admit the alteration are also aggravating factors. The absence of
23 any demonstrable harm to M.C. caused by Dr. Morgan's prescription of Aleve to her on
24 9/22/05 without either a duration or prophylactic is a factor in mitigation.

1 **ORDER**

2 Based on the Findings of Fact and Conclusions of Law as adopted, the Board
3 hereby issues a Letter of Reprimand in Board Case No. MD-05-1180A and a Letter of
4 Reprimand in Case No. MD-07-0195A against License No. 25871 previously issued to
5 John C. Morgan, MD.

6 It is further ordered that Respondent pay the costs of hearing, not to exceed
7 \$20,000.

8 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

9 Respondent is hereby notified that he has the right to petition for a rehearing or review by
10 filing a petition with the Board's Executive Director within thirty (30) days after service of
11 this Order. A.R.S. § 41-1092.09. The petition must set forth legally sufficient reasons for
12 granting a rehearing. A.C.C. R4-16-102. Service of this order is effective five (5) days
13 after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes
14 effective thirty-five (35) days after it is mailed to Respondent.

15 Respondent is further notified that the filing of a motion for rehearing is required to
16 preserve any rights of appeal to the Superior Court.
17

18 Dated this 5th day of August 2008.

19 ARIZONA MEDICAL BOARD

20 (SEAL)



22

23 By: _____

24 Lisa Wynn
25 Executive Director

1 Original of the foregoing filed this
2 20th day of August, 2008, with:

3 Arizona Medical Board
4 9545 East Doubletree Ranch Road
5 Scottsdale, AZ 85258

6 COPY OF THE FOREGOING FILED
7 this 20th day of August, 2008:

8 Cliff J. Vanell, Director
9 Office of Administrative Hearings
10 1400 W. Washington, Ste 101
11 Phoenix, AZ 85007

12 EXECUTED Copy of the foregoing
13 Mailed by Certified Mail this
14 20th day of August, 2008, to:

15 Calvin L. Raup, Esq.
16 Michael Golder, Esq.
17 Raup & Hergenroether, PLLC
18 One Renaissance Square
19 Two North Central Avenue, Suite 1100
20 Phoenix, AZ 85004
21 *Attorneys for Respondent*

22 John C. Morgan, M.D.
23 (address of record)

24 EXECUTED Copy of the foregoing
25 Mailed by Certified Mail this
20th day of August, 2008, to:

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Secretary
#225762