

ARIZONA STATE BOARD OF NURSING  
4747 North 7th Street, Suite 200  
Phoenix, Arizona 85014-3655  
602-771-7800

IN THE MATTER OF THE REGISTERED  
NURSE LICENSE NO. RN082346 AND  
ADVANCED PRACTICE NURSE NO. AP1129  
ISSUED TO: JULIE A STOTT  
RESPONDENT

CONSENT FOR ENTRY OF  
VOLUNTARY SURRENDER  
ORDER NO. 1209148

A complaint charging Julie A Stott ("Respondent") with violation of the Nurse Practice Act has been received by the Arizona State Board of Nursing ("Board"). In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements, and the responsibilities of the Board, and pursuant to A.R.S. § 32-1605.01(D), Respondent voluntarily surrenders her license and advanced practice certificate for a minimum of 5 years.

Based on the evidence before it, the Board makes the following Findings of Fact, Conclusions of Law:

**FINDINGS OF FACT**

1. Julie A. Stott ("Respondent") holds Board issued registered nurse license no. RN 082346 and advanced practice nurse no. AP1129.

2. y action. Respondent also understands that she may not reapply for rePain Centre of Mesa, Arizona and providing primary care services to patients with chronic pain. The applicable standards of care for the patients at issue in this case include the following:

**a. Standard of Care # 1 Prescribing Long-Term Opioid Medications:**

Prior to prescribing long term opioid medications for chronic non-malignant pain, it is standard of care for a nurse practitioner (NP) to conduct an appropriate evaluation of the pain problem and

1 identify the pain generator. This evaluation includes the NP taking a pain history, reviewing the  
2 patient's previous and current medical records, conducting a targeted physical exam, taking a drug  
3 history including verification of current prescriptions, and considering concomitant medical/psychiatric  
4 problems that may impact pain management. Each patient's treatment plan should be individualized and  
5 include consideration of a multidisciplinary approach/collaboration with other medical experts, i.e.  
6 orthopedics, neurologist, physical therapists, and psychiatry as appropriate.  
7

8 **b. Standard of Care # 2 History and Physical Examination for Chronic Pain**  
9 **Patients:**

10 A medical history and physical examination should be conducted and documented in the  
11 medical record. The evaluation should include documentation on the presence of one or more  
12 recognized indications for the use of a controlled substances. Professionally recognized indications for  
13 the continuous use of opioids for chronic pain, include but are not limited to situations where the cause  
14 of pain cannot be removed or otherwise treated, cancer pain, surgery, trauma, pain that is not relieved  
15 by other modalities. The patient's health history should be corroborated by reviewing the patient's  
16 health care records and/or speaking with the patient's former health care providers.  
17

18 **c. Standard of Care # 3 Pain Assessment and Evaluation of the Patient**

19 Pain assessment should occur during initial evaluation, after each new report of pain, at  
20 appropriate intervals after each pharmacological intervention, and at regular intervals during treatment.  
21 The evaluation should include a physical examination, including a neurologic evaluation and  
22 examination of the site of pain.

23 **d. Standard of Care # 4 Treatment Plan for the Chronic Pain Patient**

24 A treatment plan should be developed for the management of chronic pain and state objectives  
25 by which therapeutic success can be evaluated, including improvement in pain intensity; improvement  
26 in physical function and/or psychosocial function; proposed diagnostic evaluations; potential  
27 inclusion/exclusion criteria for opioid management and exploration of other treatment modalities and/or  
28 rehabilitation programs as indicated.  
29

1 e. **Standard of Care #5 Evaluation of patient's safety risk through utilization of**  
2 **drug Screen testing and review of Controlled Substance Prescription**  
3 **Monitoring Program (CSPMP) profile**

4 Evaluation of whether the patient is a candidate for treatment with controlled substance  
5 medications should be based on the provider's assessment and documentation of the patient's safety  
6 risk, including periodic urine drug screen testing to detect the presence of the prescribed medications  
7 and presence of illegal or illicit substances and review of CSPMP profile to ensure the patient is not  
8 obtaining controlled substances from multiple providers or diverting medication.

9 f. **Standard of Care #6 for the Diagnosis and Treatment of Anxiety**

10 The standard of care for the screening, diagnosis and treatment of Generalized Anxiety Disorder  
11 (GAD) includes periodic assessment using an evidenced based, professionally accepted, reliable and  
12 valid screening tool- such as use of the seven-item anxiety scale (GAD-7), The Generalized Anxiety  
13 Disorder Severity Scale (DGSS) or the Hamilton Anxiety Scale (HAM-A) and Clinical Global  
14 Impression Severity Scale (CGI-S). The newly developed Daily Assessment of Symptoms-Anxiety  
15 (DAS-A) scale was also shown to have validity as a new instrument to assess onset of symptomatic  
16 improvement in GAD (Feltner et al., 2009). When medication is used to treat GAD, first line  
17 medications include selective serotonin reuptake inhibitors (SSRIs) or serotonin norepinephrine  
18 reuptake inhibitors (SNRIs). In cases of co-occurring GAD and depression, a common co-morbidity,  
19 SSRIs, or SNRIs can provide effective treatment for both disorders. Second-line medications for GAD  
20 include tricyclic antidepressants, benzodiazepines, and certain anti-convulsants.

21 g. **Standard of Care #7 Diagnosis and management of Narcolepsy**

22 The diagnosis of narcolepsy and/or narcolepsy with cataplexy is commonly confirmed with a  
23 polysomnogram (sleep study) that rules out other sleep disorders, and a MSLT (multiple sleep latency  
24 test) that demonstrates average sleep latency. First line pharmacotherapy for Narcolepsy, is Provigil  
25 (Modafinil), a non-amphetamine Dopamine re-uptake inhibitor. Second line pharmacotherapeutic  
26 treatment of narcolepsy include amphetamines. Amphetamines are central nervous system stimulants  
27 and are considered second-line agents because their sympathomimetic side effects can be problematic.  
28  
29

1 Adderall, Aderall XR, Desoxyn, methamphetamine, and amphetamine salts, are all part of a class of  
2 drug called sympathomimetic. These drugs mimic symptoms similar to adrenaline and carry a black  
3 box warning label due to their abuse potential, drug dependence, serious cardiovascular adverse events  
4 and sudden death. First line pharmacotherapy for cataplexy is serotonin and nor-epinephrine re-uptake  
5 inhibitors. It is standard of care for a nurse practitioner providing primary care treatment to care for the  
6 patient in collaboration with a neurologist, pulmonologist or sleep study specialist.

7 3. On or about October 2011 through June 13, 2012, Respondent purchased from online  
8 sources "Peptides" and oxytocin, which were not approved by the FDA, and some of which were  
9 illegally imported from China. Peptides illegally imported from China included vials of "GHRP"  
10 which were labeled "not for human use". Respondent removed and replaced warning labels with her  
11 own office labels, and then sold the peptide vials for profit. Respondent admitted to these actions during  
12 an audio taped interview with Mesa Police Department Detective and FDA Agent on or about June 13,  
13 2012 and then during a personal interview at the Board of Nursing, with Board staff and Respondent's  
14 attorney, on or about March 1, 2013.

16 4. On October 16, 2012, Mesa Police Detective provided Board staff with copies of text  
17 conversations between Respondent and FDA suspect identified as M.U., (who was also a patient of  
18 Respondent), from whom Respondent purchased "peptides", and discussed the sale of "lyophilized  
19 oxytocin" to other patients of Health and Pain Management Center for \$50.00 per vial.

21 5. From in or around October 2011 through November 2012, Respondent provided health  
22 care and pain management services to patient C.W., a patient with reports of chronic pain. While  
23 providing care for C.W.:

24 a. Respondent failed to follow standard of care #1 for a patient with chronic pain by  
25 failing to conduct a thorough evaluation of patient's chronic pain problem and neglected to  
26 document a comprehensive pain history, review the patient's previous medical records, conduct  
27 a targeted physical exam, take a detailed drug history; including verification of current  
28 prescriptions, or document that Respondent addressed other concomitant medical/psychiatric  
29 problems that may impact effective pain management. Failing to follow the standard of care

1 placed patient C.W. at risk for poor management of disease progression and complications of  
2 chronic pain, such as increased pain, reduced physical mobility, decreased quality of life,  
3 overdose, depression and diversion of controlled substances.

4 b. Respondent failed to follow standard of care #2 for a patient with chronic pain by  
5 failing to conduct and document a thorough medical history and physical examination.  
6 Evaluation and documentation of a thorough medical history and physical examination for a  
7 patient with chronic pain includes, documentation of the presence of one or more recognized  
8 indications for the use of a controlled substance; for example, persistent pain in which the cause  
9 of pain cannot be removed or otherwise treated; including but not limited to, cancer pain,  
10 surgery, trauma, pain that is not relieved by other modalities. The patient's health history should  
11 be corroborated by reviewing the patient's health care records and/or speaking with the patient's  
12 former health care providers. By deviating from standard of care #2, Respondent placed patient  
13 C.W. at risk for inappropriate use of controlled substances which can lead to addiction and  
14 accidental overdose, resulting in patient harm, up to and including death.

15 c. Respondent failed to follow standard of care #3 when she continued to prescribe  
16 controlled substances for chronic pain despite lack of a thorough pain assessment during initial  
17 physical evaluation, after each new report of pain, at appropriate intervals after pharmacological  
18 intervention, and at regular intervals during treatment. By deviating from standard of care #3,  
19 Respondent placed patient C.W. at risk for poorly controlled pain management and/or over use  
20 of highly addictive and potentially toxic controlled substances with reckless disregard to their  
21 efficacy and safety.

22 d. Respondent deviated from standard of care #4 when she failed to discuss,  
23 develop and document a collaborative and comprehensive treatment plan for patient C.W.,  
24 which included objectives by which therapeutic success can be evaluated; such as realistic  
25 improvement in pain intensity, improvement in physical and/or psychosocial function,  
26  
27  
28  
29

1 proposed diagnostic evaluations, potential inclusion/exclusion criteria for opioid management,  
2 and exploration of other treatment modalities and/or rehabilitation programs as indicted.

3 e. Respondent deviated from standard of care #5 when she continued to prescribe  
4 highly addictive and potentially toxic medications without initiating or documenting a full  
5 assessment of patient C.W.'s safety risk, or whether the patient is a candidate for treatment with  
6 controlled substances. By deviating from standard of care #5 Respondent was unable to confirm  
7 the presence of prescribed medications, the presence of illegal or illicit substances, or monitor  
8 for incidences of multiple prescribing of controlled substances from other providers; placing  
9 patient C.W. and the public at risk by neglecting to ensure C.W. was taking medication as  
10 prescribed, and not deviating or abusing controlled substance medications.  
11

12 6. On or about October 2011 through October 2012, Respondent provided health care and  
13 pain management services to patient J.E., a patient with reports of chronic pain. While providing care  
14 for J.E.:

15 a. Respondent failed to follow standard of care #1 for a patient with chronic pain by  
16 failing to conduct a thorough evaluation of patient's chronic pain problem and neglecting to  
17 document a comprehensive pain history, review the patient's previous medical records, conduct  
18 a targeted physical exam, take a detailed drug history; including verification of current  
19 prescriptions, or document that Respondent addressed other concomitant medical/psychiatric  
20 problems that may impact effective pain management. Failing to follow the standard of care  
21 placed patient J.E., at risk for poor management of disease progression and complications of  
22 chronic pain, such as increased pain, reduced physical mobility, decreased quality of life,  
23 overdose, depression and diversion of controlled substances.  
24

25 b. Respondent failed to follow standard of care #2, by failing to conduct and  
26 document a thorough medical history and physical examination. By deviating from standard of  
27 care #2, Respondent placed the patient at risk for inappropriate use of controlled substances  
28  
29

1 which can lead to addiction and accidental overdose resulting in patient harm, up to and  
2 including death.

3 c. Respondent failed to follow standard of care #3 when she continued to prescribe  
4 controlled substances for chronic pain and failed to perform a thorough pain assessment; during  
5 initial physical evaluation, after each new report of pain, at appropriate intervals after  
6 pharmacological intervention, or at regular intervals during treatment. By deviating from  
7 standard of care #3, Respondent placed patient J.E. at risk for poorly controlled pain  
8 management and/or over use of highly addictive and potentially toxic controlled substances with  
9 reckless regard to their efficacy and safety.  
10

11 d. Respondent deviated from standard of care #4 when she failed to discuss,  
12 develop and document a collaborative and comprehensive treatment plan for patient J.E., which  
13 included objectives by which therapeutic success could be evaluated; such as improvement in  
14 pain intensity, improvement in physical and/or psychosocial function, proposed diagnostic  
15 evaluations, potential inclusion/exclusion criteria for opioid management, and exploration of  
16 other treatment modalities and/or rehabilitation programs as indicated.  
17

18 e. Respondent deviated from Standard of Care #5 when she failed to complete a  
19 safety risk evaluation through utilization of drug Screen testing and review of the Controlled  
20 Substance Prescription Monitoring Program (CSPMP) profile. By neglecting to perform a safety  
21 risk evaluation, Respondent was not able to verify patients were taking their medications as  
22 prescribed, thereby placing the following patients at risk for harm from prescription medication  
23 overdose, and the public at risk for diversion.  
24

25 a) From in and around September 2011 through December 2012, Respondent deviated  
26 from standard of care #5 when she continued to prescribe controlled substances to  
27 Patient J.E. without performing a safety risk evaluation. By deviating from the  
28 standard of care, Respondent failed to recognize that:  
29

1 (1) In 2011 patient J.E. received controlled medications from 22 providers;  
2 receiving a total of 6195 tablets of assorted opioids, and 2864 tablets of  
3 benzodiazepines. During this time in 2011, (October, November and  
4 December, 2011), Respondent prescribed patient J.E. approximately 683  
5 tablets of assorted benzodiazepines and 1904 tablets of opioids, with an  
6 additional 148 tablets of Soma.

7  
8 (2) In 2012 Patient J. E. received controlled medication from three different  
9 providers. During this time, Respondent prescribed approximately 3506  
10 tablets of assorted benzodiazepines and 14,893 tablets of opioids, with an  
11 additional 1680 tablets of Soma.

12  
13 f. Respondent deviated from standard or care #6 when she failed to utilize standard  
14 guidelines for screening, diagnosis, and treatment of Generalized Anxiety Disorder (GAD). By  
15 neglecting to follow the standard of care, Respondent placed patient J.E. at risk for  
16 complications from inappropriate diagnosis, poor disease management, and exposed patient J.E.  
17 to potentially harmful and addictive controlled substance medications.

18  
19 7. From in or around January 5, 2011 through November 21, 2012, Respondent provided  
20 health care and pain management services to patient D.P., a patient with reports of chronic pain. While  
21 providing care for D.P.:

22  
23 a. Respondent deviated from standard of care #1 by failing to conduct a thorough  
24 evaluation of patient's chronic pain problem and neglecting to document a comprehensive pain  
25 history, review the patient's previous medical records, conduct a targeted physical exam, take a  
26 detailed drug history; including verification of current prescriptions, or document that  
27 Respondent addressed other concomitant medical/psychiatric problems that may impact  
28 effective pain management. Failing to follow the standard of care placed patient D.P., at risk for  
29

1 poor management of disease progression and complications of chronic pain, such as increased  
2 pain, reduced physical mobility, decreased quality of life, overdose, depression and diversion of  
3 controlled substances.

4 b. Respondent failed to follow standard of care #2 by failing to conduct and  
5 document a thorough medical history and physical examination. By deviating from standard of  
6 care #2, Respondent placed patient at risk for inappropriate use of controlled substances which  
7 can lead to addiction and accidental overdose resulting in patient harm, up to and including  
8 death.

9 c. Respondent failed to follow standard of care #3 when she continued to prescribe  
10 controlled substances for chronic pain despite lack of a thorough pain assessment during initial  
11 physical evaluation, after each new report of pain, at appropriate intervals after pharmacological  
12 intervention, and at regular intervals during treatment. By deviating from standard of care #3,  
13 Respondent placed patient D.P., at risk for poorly controlled pain management and/or over use  
14 of highly addictive and potentially toxic controlled substances with reckless disregard to their  
15 efficacy and safety.

16 d. Respondent deviated from standard of care #4 when she failed to discuss,  
17 develop and document a collaborative and comprehensive treatment plan for patient D.P., which  
18 included objectives by which therapeutic success can be evaluated; such as improvement in  
19 pain intensity, improvement in physical and/or psychosocial function, proposed diagnostic  
20 evaluations, potential inclusion/exclusion criteria for opioid management, and exploration of  
21 other treatment modalities and/or rehabilitation programs as indicted.

22 e. Respondent deviated from standard of care #5 when she continued to prescribe  
23 highly addictive and potentially toxic medications without initiating or documenting a full  
24 assessment of patient D.P.'s safety risk, or whether the patient is a candidate for treatment with  
25 controlled substances. By deviating from standard of care #5 Respondent was unable to confirm  
26 the presence of prescribed medications, the presence of illegal or illicit substances, or monitor  
27  
28  
29

1 for incidences of multiple prescribing of controlled substances from other providers; placing  
2 patient D.P. and the public at risk by neglecting to ensure D.P. was taking medication as  
3 prescribed, and not deviating or abusing controlled substance medications.

4 8. From around October 31, 2011 through November 21, 2012, Respondent deviated from  
5 standard of care #7; when providing patient N.J. with medication to treat Narcolepsy she continued to  
6 prescribe increasing amounts and/or initiate doses of Adderall, Adderall XR, amphetamine salts,  
7 Desoxyn, Modafinil (Provigil), and Xyrem without diagnostic documentation of a Narcolepsy  
8 diagnosis, and without indications that other sleep or neurological disorders had been ruled out; without  
9 documentation of collaboration with a neurologist, pulmonologist or sleep study specialist, and without  
10 evidence of a polysomnogram in patient N.J.'s medical chart. Additionally, Respondent failed to  
11 follow the standard of care in the recommended treatment of narcolepsy with cataplexy, or document  
12 rationale for deviation from the standard of care treatment. By failing to follow standard of care #7 for  
13 diagnosis and management of Narcolepsy, or document collaboration with a specialist in the area of  
14 narcolepsy, Respondent placed patient N.J. at risk of poor disease management and treatment outcomes,  
15 and exposed N.J. to multiple medications without monitoring for side effects, efficacy of medications,  
16 or risk for diversion.

17  
18  
19 9. From around October 31, 2011 through November 21, 2012 Respondent deviated from  
20 standard of care #5 when she continued to prescribe controlled substances to Patient N.J. without  
21 performing a safety risk evaluation. By deviating from the standard of care, Respondent failed to  
22 recognize that:

23  
24 (1) In 2011 Patient N.J. had a total of 14 different providers writing for controlled  
25 substances, of which 2419 tablets were amphetamine drugs; of that amount, Respondent  
26 prescribed 150 tablets.

1 (2) In 2012 Patient N.J. had a total of 3 different providers writing for controlled  
2 substances, of which 6635 tablets were amphetamine drugs; of that amount, Respondent  
3 prescribed 6300 tablets.

4 (3) Additionally, Respondent prescribed N.J. other controlled substances to include  
5 testosterone, opioids, and medications commonly seen in narcolepsy i.e. Xyrem and  
6 Modafinil without documentation of a safety evaluation in the medical chart.  
7

8 10. From in and around October 31, 2011 through November 21, 2012 Respondent exceeded  
9 her scope of practice when she failed to recognize the limits of her knowledge and experience and  
10 neglected to consult with a physician or other health care provider with expertise in treating narcolepsy  
11 with cataplexy while caring for patient N.J.  
12

13 11. From in and around October 2011 through October 2012, Respondent exceeded her  
14 scope of practice when she failed to recognize the complexity of treating patient J.E., a patient with the  
15 medical history of chronic pain and drug use disorder, by failing to consult with a physician, or other  
16 health care provider, with the expertise in drug addiction and the management of chronic pain. By  
17 continuing to prescribe J.E. with increasing doses of highly addictive controlled substances, Respondent  
18 placed the health and welfare of patient J.E. at risk for exacerbating her drug addiction, risk of narcotic  
19 overdose and death.  
20

21 12. From on or about February 23, 2012 and June 18, 2012, Respondent exceeded her scope  
22 of practice when she prescribed Oxytocin 50IU to patient C.W. for purposes not consistent with Federal  
23 Drug Agency guidelines or evidenced based guidelines. By proscribing a drug for purposes other than  
24 what is indicted or supported by evidenced based practice, Respondent placed C.W. at risk for serious  
25 side effects and poor disease management.  
26

27 13. On or about September 25, 2013, Respondent requested to voluntary surrender her  
28 license and advanced practice certificate.  
29

1 CONCLUSIONS OF LAW

2 Pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664, the Board has subject matter and  
3 personal jurisdiction in this matter.  
4

5 The conduct and circumstances alleged in the Findings of Fact (specifically Findings of Fact 1-  
6 12) constitute violations of the Act, specifically unprofessional conduct, as described in A.R.S. § 32-  
7 1663(D) (effective September 30, 2009) and as defined in A.R.S. § 32-1601 (18) and A.R.S. § 32-  
8 1663(D) (effective August 2, 2012) and as defined in A.R.S. § 32-1601 (22) "Unprofessional conduct"  
9 includes the following whether occurring in this state or elsewhere: (d) Any conduct or practice that is  
10 or might be harmful or dangerous to the health of a patient or the public; (g) Willfully or repeatedly  
11 violating a provision of this chapter or a rule adopted pursuant to this chapter; (j) Violating a rule that is  
12 adopted by the board pursuant to this chapter,  
13  
14

15 The conduct and circumstances alleged in the Findings of Fact (specifically Findings of Fact 10-  
16 11) constitute violations of A.R.S. §32-1601 (19) (d) (vi 6)Recognizing the limits of the nurse's  
17 knowledge and experience and planning for situations beyond the nurse's knowledge, educational  
18 preparation and expertise by consulting with or referring clients to other health care providers when  
19 appropriate.  
20

21 The conduct and circumstances alleged in the Findings of Fact (specifically Findings of Fact 1-  
22 12) violate the Arizona Administrative Code (A.A.C.) Rule(s) 4-19-403 (effective January 31, 2009):  
23 (1) A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice;  
24 (7) Failing to maintain for a patient record that accurately reflects the nursing assessment, care,  
25 treatment, and other nursing services provided to the patient;(18) Obtaining, possessing, administering,  
26 or using any narcotic, controlled substance, or illegal drug in violation of any federal or state criminal  
27 law, or in violation of the policy of any health care facility, school, institution, or other work location at  
28  
29

1 which the nurse practices; (31) Practicing in any other manner that gives the Board reasonable cause to  
2 believe the health of a patient or the public may be harmed.

3  
4 The conduct and circumstances alleged in the Findings of Fact (specifically Findings of Fact 10-  
5 11) violate A.A.C. § R4-19-508(a), (c) (effective January 31, 2009). (a) An RNP shall refer a patient  
6 to a physician or another health care provider if the referral will protect the health and welfare of the  
7 patient and consult with a physician and other health care providers if a situation or condition occurs in  
8 a patient that is beyond the RNP's knowledge and experience (Fact 23, 24) (c) An RNP shall only  
9 provide health care services within the nurse practitioner's scope of practice for which the RNP is  
10 educationally prepared and for which competency has been established and maintained. Educational  
11 preparation means academic coursework or continuing education activities that include both theory and  
12 supervised clinical practice (Fact 23, 24)

13  
14  
15 The conduct and circumstances described in the Findings of Fact constitute sufficient cause  
16 pursuant to A.R.S. §§ 32-1605.01(D) and 32-1664(N) to take disciplinary action against Respondent's  
17 license to practice as a registered nurse/advance practitioner nurse in the State of Arizona.

18  
19 Respondent admits the Board's Findings of Fact, Conclusions of Law.

20 In lieu of a formal hearing on these issues, Respondent agrees to issuance of the attached Order  
21 and waives all rights to a hearing, rehearing, appeal or judicial review relating to this matter.

22 Respondent further waives any and all claims or causes of action, whether known or unknown, that  
23 Respondent may have against the State of Arizona, the Board, its members, offices, employees and/or  
24 agents arising out of this matter.

25  
26 Respondent understands that all investigative materials prepared or received by the Board  
27 concerning these violations and all notices and pleadings relating thereto may be retained in the  
28 Board's file concerning this matter.  
29

1 Respondent understands that the admissions in the Findings of Fact are conclusive evidence of  
2 a violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any  
3 future disciplinary matter.  
4

5 Respondent understands the right to consult legal counsel prior to entering into the Consent  
6 Agreement and such consultation has either been obtained or is waived.  
7

8 Respondent understands that this voluntary surrender is effective upon its acceptance by the  
9 Executive Director or the Board and by Respondent as evidenced by the respective signatures thereto.  
10 Respondent's signature obtained via facsimile shall have the same effect as an original signature.  
11 Once signed by Respondent, the agreement cannot be withdrawn without the Executive Director or  
12 the Board's approval or by stipulation between Respondent and the Executive Director or the Board.  
13 The effective date of this Order is the date the Voluntary Surrender is signed by the Executive  
14 Director or the Board and by Respondent. If the Voluntary Surrender is signed on a different date, the  
15 later date is the effective date.  
16

17 Respondent understands that Voluntary Surrender constitutes disciplinary action. Respondent  
18 also understands that she may not reapply for re-issuance during the period of Voluntary Surrender.  
19

20 Respondent agrees that she may apply for re-issuance after the period of voluntary surrender  
21 under the following conditions, and must comply with current law at the time of their application for  
22 re-issuance:  
23

24 \ \ \ \

25 \ \ \ \

26 \ \ \ \

27 \ \ \ \

28 \ \ \ \

29 \ \ \ \

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29

The application for re-issuance must be in writing and shall contain therein or have attached thereto substantial evidence that the basis for the voluntary surrender has been removed and that the re-issuance of the license does not constitute a threat to the public's health, safety and welfare. The Board may require physical, psychological, or psychiatric evaluations, reports and affidavits regarding Respondent as it deems necessary. These conditions shall be met before the application for re-issuance is considered.

  
Julie A. Stott

Date: 9-25-13

ARIZONA STATE BOARD OF NURSING

SEAL

  
Nikki Austin, JD, RN  
Associate Director/Investigations Compliance

Dated: 9/27/13

ORDER

Pursuant to A.R.S. § 32-1605.01(D) the Board hereby accepts the Voluntary Surrender of registered nurse license number RN082346 and advanced practice certificate number AP1129 issued to Julie A. Stott. This Order of Voluntary Surrender hereby entered shall be filed with the Board and shall be made public upon the effective date of this Consent Agreement. Respondent shall not practice in Arizona under the privilege of a multistate license.

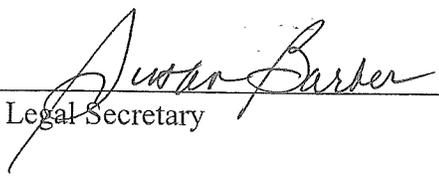
IT IS FURTHER ORDERED that Respondent may apply for re-issuance of said license after a period of 5 years.

1 COPY mailed this 27<sup>th</sup> day of Sept, 2013, by First Class Mail to:

2 Dave Derickson, Esq.  
3 Ridenour Hienton & Lewis PLLC  
4 201 N. Central Avenue, Suite 3300  
5 Phoenix, AZ 85004-1052  
6 Attorneys for Respondent

7 COPY mailed this 27<sup>th</sup> day of Sept, 2013, by First Class Mail to:

8 Julie A. Stott  
9 6546 E. Riverdale Street  
10 Mesa, AZ 85215

11 By:   
12 Legal Secretary