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

LICENSE RENEWAL APPLICATION TO PRACTICE IN CALENDAR YEARS 2019 and 2020

Biennial Renewal Fee: $636.00 (if postmarked by January 31, 2019)
$811.00 (if postmarked between February 1 and April 30, 2019)

This two page form may be sent by mail, email, or delivered. Allow up to 30 days for processing. To renew online, please go to Online Renewal at www.azdo.gov > For DOs > Online License Renewal. Fees are the same.

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

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

Physician's Name _____ **AZ License Number:** _____

1. ADDRESS OF RECORD: Osteopathic Statutes require you to provide your **ADDRESS OF RECORD**. Your address of record is usually the address where you practice medicine or are otherwise employed. If you do not indicate a practice address below, you are providing written request to the Board to use your residential address as your address of record and it may be available to the public (A.R.S. § 32-1800(2) & A.R.S. § 32-3801). Your address of record does NOT need to be an Arizona address.

MAILING ADDRESS: You may designate a mailing address by checking the appropriate box below. Also, please provide your email address. Email addresses are not published.

Practice address. ☐ By checking this box, I am requesting the Board use my practice address as my **mailing address.**		**Residential address.** ☐ By checking this box, I am requesting the Board use my residential address as my **mailing address**.
Name of Practice:		Street Address:
Street Address:		City, State, Zip:
Street Address:		Home Number:
City, State, Zip:		Cell Number:
Office Number:	Fax Number:	Email Address:

2. SPECIALTY/AREA OF PRACTICE: Please review your profile on our website at www.azdo.gov > Doctor Search. If there are any changes to your profile, please list them below. If you have become board certified in your specialty since licensure or your last renewal, please list your certification below and include a copy of your certificate or letter from the certifying board. This Board only recognizes the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) and the American Board of Medical Specialties (ABMS).

Name of Specialty (Refer to listing of specialties at www.azdo.gov)	**Specialty Organization (check one)**		**Date awarded**	**Date expires**
	AOA-BOS	**ABMS**		

Physician's Name _____ **AZ License Number:** _____

THIS PAGE MUST BE COMPLETED AND SIGNED BY THE RENEWING PHYSICIAN

Failure to properly answer the questions below may result in Board disciplinary action including revocation of license.

3. UPDATE PROFESSIONAL CONDUCT HISTORY: If you answer "yes" to any of the following questions, please attach an explanation of the situation on a separate blank sheet of paper. As appropriate, attach copies of documents from hospitals, programs, State Boards, courts and law enforcement agencies confirming your explanation. **During the past two (2) years have you been notified or made aware:**	**YES**	**NO**
A. That you were arrested for, charged with or convicted of any felony, or any misdemeanor? You must answer "yes" even if the offense occurred outside of Arizona, the case has not yet been adjudicated, you completed a diversion program, you received a suspended sentence or probation, the convictions were dismissed or set aside, your sentence was commuted, the records were expunged, your civil rights were restored or you received a pardon.		
B. That you had disciplinary or adverse action imposed against any professional license, or that you were denied a professional license, or have you entered into any consent agreement, stipulated order, or settlement with any regulatory board; OR have you been notified of any complaints or investigations against your license that have not yet been resolved?		
C. That your DEA permit or prescription permit issued by any regulatory board been denied, restricted, suspended, lost, or had any other adverse action taken against it, OR have you been notified of any complaints or investigations against your authority to prescribe that have not yet been resolved?		
D. That any award, settlement, or payment of any kind been made by you or on your behalf to resolve a civil suit or malpractice claim involving your practice even if it was not required to be reported to the National Practitioner Data Bank; OR have you been notified that any such suit or claim is pending?		
E. That your hospital privileges or health care program affiliations were denied, restricted, lost, suspended or modified, or subjected to any other adverse action even if that action was not required to be reported to the National Practitioner Data Bank; OR have you been notified of any complaints against or reviews of your privileges or affiliations that have not yet been resolved?		

4. CONFIDENTIAL QUESTIONNAIRE: If you answer "yes" to either of the following questions, you must submit a detailed written narrative statement concerning matter(s) including the name of the healthcare providers and treatment centers where you were treated along with the discharge summary of your treatment and progress. If you are currently participating or have participated in the past five (5) years, pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of doctors of osteopathic medicine impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with compliance reports from the state monitoring programs**.** **During the past two (2) years have you been notified or made aware:**	**YES**	**NO**
A. That you were diagnosed with or developed initial or worsening symptoms of a physical, mental, or emotional condition which did or may impair or limit your ability to safely practice medicine?		
B. That you entered into a diversion program for treatment and monitoring for substance abuse or dependency, or for correction of communication or boundary issues, in lieu of or as a condition of resolving a matter before a regulatory board, criminal or civil court? You must answer "Yes" even if you received a pardon, the convictions were set aside, the records were expunged, your civil rights were restored and whether or not the sentence was imposed or suspended.		

5. COMPLIANCE WITH CME REQUIREMENT

I have **NOT been noticed** for CME Audit

____ I am in compliance with the CME requirement. I have completed at least forty (40) hours of CME which included at least twenty-four (24) hours of Category 1A CME and the remaining balance of sixteen (16) hours of any other CME category including AMA Category 1 CME during the calendar years 2017 and 2018 or during an approved extension period.

I have **been noticed** for CME Audit

____ I am in compliance with the CME requirement**.** I have included, with my Renewal, activity reports from my certifying board and/or the AOA and all Certificates of Completion for CME not otherwise accounted for on my activity reports **or have submitted a waiver or extension request.**

The CME FAQ, CME Audit Form and Forms for Extensions and/or Waivers of CME are available on the Board's website: www.azdo.gov > For DOs > License Renewal Forms

6. SIGN AND DATE THIS FORM

I, the undersigned, do hereby attest that the information I have provided the Board on this application and in the supporting documentation is true, complete and accurate.

Physician Signature _____ Date signed _____

License holder must sign the form. Electronic or stamped signatures are not valid and not accepted.

Please include Payment with your application. Make check payable to "Arizona Osteopathic Board".
We do not accept credit card payment by email or fax; however, payment may be called in over the phone.

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CREDIT CARD PAYMENT FORM

Name of Physician:_____, D.O. License No. _____

Item/Service Requested: _____ Amount $ _____

PLEASE COMPLETE AND RETURN THIS FORM IF PAYING BY CREDIT CARD
We do not accept this form by fax or email. Payment can be mailed or called in over the phone.

If you filed an extension on or before January 31st, or are renewing by January 31st, renewal fee is $636.00.

If you are renewing your license AFTER January 31st, you must pay the late fee of $175.00 in addition to the $636.00 renewal fee. The total owed to renew AFTER January 31st is $811.00.

PAYMENT AMOUNT:
On or before January 31: $ 636.00
On or after February 1: $ 811.00

Name as Shown on Payment Card: _____

Billing Address: (Required)

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number of Card Holder: (Required) _____

Mailing Address (Required if different from billing address)

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number of Card Holder: (Required) _____

Signature of Cardholder: _____ **Date**: _____

Type of Card: ☐ Visa ☐ MasterCard ☐ American Express

Visa or MasterCard #: _____ - _____ - _____ - _____

American Express #: _____ - _____ - _____

Expiration Date: _____ (MM/YY)

Note: The Board shreds this form after payment has been authorized by your credit card company