



**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 VERIFICATION REQUEST FORM**

*Use this form to request that a verification of licensure and disciplinary history be sent to another board or organization.*

**FEE:** Please mail your request and a check payable to the Arizona Board of Osteopathic Examiners in the amount of \$10.00 per verification to the address listed above. Payment may also be made by credit card by faxing the request and credit card information to 480-657-7715. The information released with this request is public. Therefore, no signature is required.

**Name of Licensee to be verified:** \_\_\_\_\_ **Lic. No.** \_\_\_\_\_

**Type of License to be verified:** \_\_\_\_\_ D.O. Physician \_\_\_\_\_ D.O. PGT Permit \_\_\_\_\_ D.O. Locum Tenens

**Requestor’s name, address and day phone number (If different than licensee):**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Provide below the name of each organization, facility, or regulatory board to which a verification is to be sent. All state licensing board addresses are on file, so it is not necessary to provide these.

**1. Name of Receiving Board/Organization:** \_\_\_\_\_

Address, if other than another state licensing board:

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**2. Name of Receiving Board/Organization:** \_\_\_\_\_

Address, if other than another state licensing board:

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**3. Name of Receiving Board/Organization:** \_\_\_\_\_

Address, if other than another state licensing board:

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**Verifications are mailed via United States Postal Service. If you wish to have verification sent via some other delivery service, you must provide a pre-completed waybill including the requestor’s account number for payment for each verification with this request.**

**Verifications may take up to two (2) weeks to be processed.**



# Arizona Board of Osteopathic Examiners In Medicine and Surgery

Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

## CREDIT CARD PAYMENT FORM

Name of Physician \_\_\_\_\_ Date \_\_\_\_\_  
(if applicable)

Item/Service Requested: \_\_\_\_\_

This form and your order/application may be faxed to: 480-657-7715  
If faxing this form, please do not mail the original as you may be charged twice.

Amount: \$ \_\_\_\_\_

Type of Card:  Visa  MasterCard  American Express

Visa or MasterCard #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

American Express #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_\_ (MM/YY)

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: \_\_\_\_\_

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