Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 W. Adams Street, Suite 2410, Phoenix, Arizona, 85007
Ph : 480-657-7703 | www.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 mailing this form to the address provided above. 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.

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CREDIT CARD PAYMENT FORM

Name of Physician_____ Date _____
(if applicable)

Item/Service Requested: _____ Amount $_____

We do not accept payment by fax or email. Payment must be mailed with this request

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***