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 | questions@azdo.gov

INITIAL LICENSE APPLICATION

APPLICATION FEE: $400

THIS AREA FOR OFFICIAL USE ONLY

Attach a photograph
for identification purposes
Approximately
2” x 2”
TAKEN WITHIN THE
PAST SIXTY (60) DAYS

DO NOT STAPLE PHOTO
Transparent tape at edges
is preferred

Download the license application instructions from www.azdo.gov and follow them carefully to avoid delays.

FAXED APPLICATIONS WILL NOT BE ACCEPTED. Answer all questions. Answer “none” or “N/A” if that is the correct response. If you fail to complete a question, your application will be considered deficient and the processing of your application will be delayed.

In accordance with Arizona Revised Statutes § 32-1822, you may be required to submit additional information, be evaluated for fitness to practice or appear before the Board for a personal interview in addition to submitting this application and requested documentation.

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.

Submitting this application does not authorize you to practice medicine or surgery in the State of Arizona.

SECTION 1: APPLICANT IDENTIFICATION AND CONTACT INFORMATION – REQUIRED

______________________ ______________________ ______________________
Last Name First Name Middle Name

____
Other Names Used: (Provide copies of marriage license or court records). If this does not apply to you, write N/A.

______________________________ ______________________
Mailing Address Cell/Daytime Phone Number

Gender: Male ☐ Female ☐

____
City State Zip

If using FCVS for verification of education, training and national medical exam scores, Check here: ☐

____
Email Address

Date of Birth: ____________________ Social Security Number: ____________________

SECTION 2: ALTERNATE CONTACT

You may authorize someone else to check the status of your application by providing the following information and signing below. If this section is blank, only you, the applicant, will be told the status of this application.

Name of Contact: ____ Phone Number: _____________________________

Name of Company: ____ Email: ____

Address/City/State/Zip: ____

I, ____, give authorization for the above named person to be informed of the status of my application for licensure in Arizona.

SECTION 3: PROFESSIONAL EDUCATION

Please submit Form No. 1 to the Osteopathic College from which you graduated. The form must be completed by the school Registrar or Dean and returned ***DIRECTLY*** to the Arizona Osteopathic Board in order to provide verification of your education.

Name of College or School of Osteopathic Medicine	City/State	Graduation Date (M/D/YYYY)

SECTION 4: POSTGRADUATE TRAINING

Please fill in areas completely and accurately. Please submit Form No. 2 to each postgraduate training facility/program at which you trained, regardless of completion. The form must be completed by the Program Director and returned ***DIRECTLY*** to the Arizona Osteopathic Board in order to provide verification of your training. If the facilities or programs are now defunct, please so indicate. If more space is needed, use a separate sheet.

Type of Program	Name of Institution or Program	City/State	Specialty	Dates Attended	
				Start (M/D/YYYY)	End (M/D/YYYY)
Internship/ PGY-1					
Residency					
Residency					
Residency					
Fellowship					
Fellowship					

SECTION 5: NATIONAL LICENSURE EXAMINATIONS

Please list the national licensure examinations you passed and the dates you passed. If you passed Level 3 of the COMLEX or Part 3 of the USMLE exam in the past seven (7) years, you must have an original transcript of all your scores sent directly to this agency. If it has been more than seven (7) years since you passed your licensing examinations, you do not need to have your scores sent to the Board but you still need to list them in the table below.

Name of Exam / Part or Level	Date Passed

SECTION 6: PRIMARY FIELD OF PRACTICE / BOARD CERTIFICATION OF SPECIALITIES

Please list your primary field of practice. If you are currently completing PGT, list the field in which you are training. If you are Board certified in a specialty by either AOA-BOS or a specialty board of ABMS, list those. Please write either AOA-BOS or ABMS to indicate by which Board you are certified. The Arizona Osteopathic Board does not recognize specialty certifications by other credentialing bodies. Attach a copy of each certification listed.

Primary Specialty/Field of Practice: ____

ABMS / AOA Board Specialty Certification Attach additional sheet if needed	Date Certified	Expiration Date

SECTION 7: OTHER STATE LICENSES

Please fill in the information for each license you hold or have held. If you have more than fits in the table below, please use a separate blank sheet of paper for the 'overflow' information. If you were previously licensed in Arizona, list that also. On a separate sheet of paper explain any time you were not licensed. A verification of license must be submitted from each state in which you were granted a license, regardless of the status of the license. This verification must include a current status and disciplinary history, if any.

Issuing State	License Number	Date of Issuance	Date of Expiration	License Status

SECTION 8: PRACTICE EXPERIENCE*

Provide a list of all health care facilities, clinics, urgent cares, offices, etc., at which you have practiced medicine, consulted medicine or had staff privileges, whether employed or in private practice. This list must account for all years since initial licensure. This does not include facilities at which you were doing PGT rotations. If more space is needed, please use a separate blank sheet of paper. If this information is in your CV, you may write "see CV" in the table and include your CV with your application instead.

Verification of the last seven (7) years of practice experience is required. Please send Form 3: Practice Experience Verification to the appropriate entities in order to obtain this, and then have the completed form(s) sent directly to the Board in order to maintain the integrity of the verification. We accept verifications by fax, email or mail from the verifying entities only.

*** *If you have extensive Locum Tenens history, please organize by facility, then dates on a separate sheet of paper.***

Start Date (M/D/YYYY)	End Date (M/D/YYYY)	Name of Health Care Facility or Employer	City/State

SECTION 9: PROFESSIONAL CONDUCT HISTORY

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

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.	**YES**	**NO**
1. Have you ever been 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.		
2. Have you had any disciplinary or adverse action imposed against any professional license, or were you 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?		
3. Has 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?		
4. Has 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?		
5. Have your hospital privileges or health care program affiliations been 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?		
6. During an internship, residency or fellowship program were you placed on probation, had your privileges restricted or suspended, terminated from the program or had any other adverse action taken against your participation even if that action was not required to be reported to the National Practitioner Data Bank?		

SECTION 10: PROFESSIONAL CONDUCT HISTORY - 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 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.	**YES**	**NO**
1. Have you been 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?		
2. Have you entered into a diversion program for evaluation, treatment or 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; OR have you been notified that such action is pending? 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.		

SECTION 11: ATTESTATION TO BE SIGNED BY APPLICANT AND NOTARIZED

I attest that all information submitted on or with this application is true. I am the person named on this application. I have read the statutes and rules regarding licensure and have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. I am not omitting any information which might be of value to this Board in determining my qualifications. I acknowledge that any falsification, omission, or withholding of information or facts concerning my qualifications as an applicant shall be sufficient to deny licensure or constitute grounds to revoke, suspend or cancel the license, if not discovered until after issuance. A.R.S. §§ 32-1822, -1854(9).

____, D.O.   ________________________________
Signature of Applicant   Date Signed

State of ________________________)
)
County of ________________________)

On this ______ day of ______________, 20_____ before me personally appeared ____(applicant), known to me or whose identity is proved to me by satisfactory evidence to be the person who he/she claims to be and who swore or affirmed before me that the information in this application is true, complete and correct.

Notary Public: ____

SEAL

My commission expires: ________________________________

ARIZONA STATEMENT OF CITIZENSHIP AND ALIEN STATUS FOR STATE PUBLIC BENEFITS

Professional License and Permit

Arizona Board of Osteopathic Examiners in Medicine & Surgery

Title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the "Act"), 8 U.S.C. § 1621, provides that, with certain exceptions, only United States citizens, United States non-citizen nationals, non-exempt "qualified aliens" (and sometimes only particular categories of qualified aliens), nonimmigrants, and certain aliens paroled into the United States are eligible to receive state or local public benefits. With certain exceptions, a professional license and commercial license issued by a State agency is a State public benefit.

Arizona Revised Statutes § 41-1080 requires, in general, that a person applying for a license must submit documentation to the license agency that satisfactorily demonstrates the applicant's presence in the United States is authorized under federal law.

Directions: All applicants must complete Sections I, II, and IV. Applicants who are not U.S. citizens or nationals must also complete Section III.

Submit this completed form and a copy of one or more document(s) from the attached "Evidence of U.S. Citizenship, U.S. National Status or Alien Status" with your application for license or renewal. If the document you submit does not contain a photograph, you must also provide a government issued document that contains your photograph. You must submit supporting legal documentation (i.e. marriage certificate) if the name on your evidence is not the same as your current legal name.

SECTION I – APPLICANT INFORMATION

APPLICANT'S NAME (Print or type) ____

TYPE OF APPLICATION (Check one) ☐ INITIAL APPLICATION ☐ RENEWAL

TYPE OF LICENSE/PERMIT (Check one) ☐ DO ☐ PGT ☐ Locum Tenens

SECTION II – CITIZENSHIP OR NATIONAL STATUS DECLARATION

Are you a citizen or national of the United States? ☐ Yes ☐ No

If **Yes**, indicate place of birth:

City ______________________________ State (or equivalent) _________ Country or Territory _______________________

If you answered **Yes**,

1) Attach a legible copy of one or more document(s) from the attached "Evidence of U.S. Citizenship, U.S. National Status or Alien Status" page.
Name of document ____

2) Go to Section IV.

If you answered **No**, you must complete Section III and IV.

SECTION III – ALIEN STATUS DECLARATION

To be completed by applicants who are not citizens or nationals of the United States. Please indicate alien status by checking the appropriate box. Attach a legible copy of one or more document(s) from the attached "Evidence of U.S. Citizenship, U.S. National Status or Alien Status". Name of document provided ____.

Qualified Alien Status (8 U.S.C. §§ 1621(a)(1),-1641(b) and (c))

- ☐ 1. An alien lawfully admitted for permanent residence under the Immigration and Nationality Act (INA)
- ☐ 2. An alien who is granted asylum under Section 208 of the INA.
- ☐ 3. A refugee admitted to the United States under Section 207 of the INA.
- ☐ 4. An alien paroled into the United States for <u>at least one year</u> under Section 212(d)(5) of the INA.
- ☐ 5. An alien whose deportation is being withheld under Section 243(h) of the INA.
- ☐ 6. An alien granted conditional entry under Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
- ☐ 7. An alien who is a Cuban/Haitian entrant.
- ☐ 8. An alien who has or whose child or child's parent is a "battered alien" or an alien subject to extreme cruelty in the United States.

Nonimmigrant Status (8 U.S.C. § 1621(a)(2))

- ☐ 9. A nonimmigrant under the Immigration and Nationality Act [8 U.S.C § 1101 et seq.] Nonimmigrants are persons who have temporary status for a specific purpose. See 8 U.S.C § 1101(a)(15).

Alien Paroled into the United States For Less Than One Year (8 U.S.C. § 1621(a)(3))

- ☐ 10. An alien paroled into the United States for <u>less than one year</u> under Section 212(d)(5) of the INA

Other Persons (8 U.S.C § 1621(c)(2)(A) and (C)

- ☐ 11. A nonimmigrant whose visa for entry is related to employment in the United States or
- ☐ 12. A citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99-239 or 99-658 (or a successor provision) is in effect (Freely Associated States include the Republic of the Marshall Islands, Republic of Palau and the Federate States of Micronesia, 48 U.S.C. § 1901 *et seq*.);
- ☐ 13. A foreign national not physically present in the United States.

Otherwise Lawfully Present

- ☐ 14. A person not described in categories 1-13 who is otherwise lawfully present in the United States. **PLEASE NOTE: The federal Personal Responsibility and Work Opportunity Reconciliation Act may make persons who fall into this category ineligible for licensure. See 8 U.S.C. § 1621(a).**

SECTION IV - DECLARATION

All applicants must complete this section.

I declare under penalty of perjury under the laws of the state of Arizona that the answers and evidence I have given are true and correct to the best of my knowledge.

______________________________ APPLICANT'S SIGNATURE

____________________ TODAY'S DATE

Completed two-page form may be faxed to Board office at 480-657-7715

EVIDENCE OF U.S. CITIZENSHIP, U.S. NATIONAL STATUS OR ALIEN STATUS

You must submit supporting legal documentation (i.e. marriage certificate) if the name on your evidence is not the same as your current legal name. If proof of legal status does not include a photo, a copy of a current government issued photo ID such as a driver's license or US passport is required.

Evidence showing authorized presence in the United State includes the following:

1. An Arizona driver license issued after 1996 or an Arizona non-operating identification license.
2. A driver license issued by a state that verifies lawful presence in the United States.
3. A birth certificate or delayed birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa or the Northern Mariana Islands (on or after November 4, 1986, Northern Mariana Islands local time)
4. A United States certificate of birth abroad.
5. A United States passport. ***Passport must be signed***
6. A foreign passport with a United States visa.
7. An I-94 form with a photograph.
8. A United States citizenship and immigration services employment authorization document or refugee travel document.
9. A United States certificate of naturalization.
10. A United States certificate of citizenship.
11. A tribal certificate of Indian blood.
12. A tribal or Bureau of Indian Affairs affidavit of birth.
13. Any other license that is issued by the federal government, any other state government, an agency of this state or a political subdivision of this state that requires proof of citizenship or lawful alien status before issuing the license.

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Fingerprinting Required
(A.R.S. § 32-1822(A)(9))

Effective September 1, 2017, fingerprinting is required for the following applications:

- Initial License
- Teaching License
- Locum Tenens Registration

All applicants will receive a packet from the Board that will detail the steps to comply with the fingerprint process. Please note that the fingerprint card is specific and pre-printed for the Arizona Board of Osteopathic Examiners in Medicine and Surgery (the Board). However, a digitally printed fingerprint card on form FD-258 is acceptable.

The fingerprint technician is required to fill out and date the identity verification form, place the identity verification form and the completed fingerprint card into the envelope, and seal the envelope closed. Once the envelope is sealed, the technician will return the envelope to the applicant. The applicant may mail or deliver the sealed envelope to the Board office.

Failure to return the sealed envelope with the fingerprint card and identity verification form enclosed will result in a delay in processing your application. If you have further questions, please review the Fingerprinting FAQ on the website.

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Form No. 1: PROFESSIONAL EDUCATION VERIFICATION

In applying for a license to practice medicine in Arizona, the Arizona Board of Osteopathic Examiners requires this form be completed by the **Dean or the Registrar** of the osteopathic medical school from which you graduated. This is authorization to release any information in your files of record, favorable or otherwise, ***DIRECTLY*** **to the ARIZONA BOARD OF OSTEOPATHIC EXAMINERS, 1740 W. Adams Street, Suite 2410, Phoenix, Arizona, 85007**.

Applicant Name: ____, D.O. Last 4 digits of SSN: ______________

Signature ____ Date (Month/Day/Year)_________________________

THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE OSTEOPATHIC MEDICAL SCHOOL

This certifies that ____ , D.O.
(Name of Applicant)

was enrolled in: ____
(Name of Osteopathic College of Medicine)

____
(Location – City/State)

The undersigned further certifies that the records of this institution show that the applicant was granted an Osteopathic Medical

Degree by the above named COM on: ____________________________ Date (Month/Day/Year)

COMMENTS: ____

____

____

Signature: ____ Date: _____________________________

Name Typed or Printed: ____ Title: _______________________________________

Address: ____ Phone No.: _____________________________

City/State/Zip: ____ Fax No.: ____________________________

Contact person, if different than above: ____

Email: ____

TO MAINTAIN INTEGRITY OF THE VERIFICATION, SEND ORIGINAL DIRECTLY TO THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS

Completed form may be faxed with coversheet to Board office at 480-657-7715

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Form No. 2: VERIFICATION OF POSTGRADUATE TRAINING

FOR APPLICANT: Make as many copies as needed. Mail or fax this form to the program director of each Postgraduate Training (PGT) program in which you participated regardless of completion. This completed form is a requirement of licensure in Arizona. Your signature below is authorization to release any information about you in your PGT program's files of record, favorable or otherwise DIRECTLY to the Arizona Board of Osteopathic Examiners in Medicine and Surgery.

Applicant Name: ____, D.O.

Signature ______________________________________ Date (Month/Day/Year) ____________________

THIS SECTION TO BE COMPLETED BY PROGRAM DIRECTOR

FOR PGT PROGRAM DIRECTOR: The above named individual has applied for licensure in Arizona and has stated that he/she has participated in a PGT program at your facility. He/she is required to submit this form to you for completion. Therefore, please complete this form and return it to our office at the address above.

1. Important – Program Participation: Please report internships, residencies and fellowships separately. Please report incomplete postgraduate years (PGY) separately from those successfully completed. If the postgraduate year is currently in progress, report the expected completion date in the "To" field.

PG Year(s):_______________ **DEPARTMENT/SPECIALTY:** ______________________________________

○ **Internship**
○ **Residency**
○ **Fellowship**

From: _________/_________/_________ **To:**_________/_________/_________

Successfully completed? ○ **Yes** ○ **No** ○ **In Progress**

PG Year(s):_______________ **DEPARTMENT/SPECIALTY:** ______________________________________

○ **Internship**
○ **Residency**
○ **Fellowship**

From: _________/_________/_________ **To:** _________/_________/_________

Successfully completed? ○ **Yes** ○ **No** ○ **In Progress**

PG Year(s):_______________ **DEPARTMENT/SPECIALTY:**______________________________________

○ **Internship**
○ **Residency**
○ **Fellowship**

From: _________/_________/_________ **To:** _________/_________/_________

Successfully completed? ○ **Yes** ○ **No** ○ **In Progress**

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2. The following questions apply to the PGT years stated above. Please check the appropriate response.

a. This program was approved for postgraduate training during this individual's attendance by: ○ AOA ○ ACGME ○ DUAL

b. Did this individual ever take a leave of absence or deferment/break from his/her training? ○ Yes ○ No

c. Was this individual disciplined and/or placed under investigation or on probation? ○ Yes ○ No

d. Did this individual participate in a confidential or public diversion program for substance abuse monitoring? ○ Yes ○ No

Please explain below any "Yes" response(s) to the questions above. Use a separate blank sheet of paper if more room is necessary.

3. COMMENTS: ____

____

Signature: ______________________________________ Date: ____________________

Name Typed or Printed: ______________________________ Title: ____________________

Full name of Program or Hospital: ____

Address: ______________________________________ Phone No.: ____________________

City/State/Zip: ________________________________ Fax No.: ____________________

Contact person, if different from above: ____________________ Email: ____________________

TO MAINTAIN INTEGRITY OF THE VERIFICATION, SEND ORIGINAL DIRECTLY TO THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS
Completed form may be faxed with coversheet to Board office at 480-657-7715

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Form No. 3: PRACTICE EXPERIENCE VERIFICATION

In applying for a license to practice medicine in Arizona, the Arizona Board of Osteopathic Examiners requires this form be completed by the **Medical Employer/Director** where I have practiced medicine for evaluation of my professional record and mental and physical capabilities during the seven (7) years preceding my application. This is authorization to release any information in your files of record including a standard affiliation verification letter ***DIRECTLY*** to the Arizona Board of Osteopathic Examiners, 1740 W. Adams Street, Suite 2410, Phoenix, Arizona, 85007. Faxed verifications are acceptable if accompanied by a coversheet bearing your facility's logo or letterhead.

Applicant Name: ____, D.O.

Signature ______________________________ Date (Month/Day/Year) ____________________

THIS SECTION TO BE COMPLETED BY FACILITY OFFICIAL

1. This is to certify that ____, D.O.,

held/holds the following position: ____

Dates: From: ____________________ To: ____________________
Month/Day/Year Month/Day/Year

Circle the correct response to the questions below: ("Yes" responses require written explanation.)

2. Has this individual participated in a confidential or public diversion program for substance abuse monitoring? **Yes** **No**

3. Was this individual disciplined and/or placed under investigation or on probation? **Yes** **No**

Please explain below any "Yes" response(s) to the two questions above.
Use a separate blank sheet of paper if more room is necessary.

____

____

____

Practice/Facility Being Verified: ______________________________ Phone No: ____________________

Address: ______________________________ Fax No.: ____________________

City/State/Zip: ______________________________ Email: ____________________

Name of Official (PRINT): ______________________________ Title: ____________________

Signature: ______________________________ Date: ____________________

TO MAINTAIN INTEGRITY OF THE VERIFICATION, SEND ORIGINAL DIRECTLY TO THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS
Completed form may be faxed with coversheet to Board office at 480-657-7715

Arizona Board of Osteopathic Examiners License Application
MALPRACTICE CLAIM / SUIT QUESTIONNAIRE

Complete the information below for each instance of any award, settlement or payment of any kind either 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 Practitioners Data Bank; OR if you have been notified that any such suit or claim is pending. Duplicate this form as necessary and use as a cover sheet with all supporting documentation required.

1. Applicant's name: ____

2. Name of patient: ________________ ________________ ________________
   Last name First name Middle name/initial

3. Date of occurrence: ______________________

4. Location of occurrence: ____
   Name of hospital / office / clinic) City / State

5. Current status of suit/claim: ☐ Pending ☐ Settled

   If settled, was it settled: ☐ in court ☐ out of court Date of settlement: ______ /______ /______

6. Total Amount of Settlement / Award $______________ Amount attributable to you $______________

7. Name of your insurance company: ______________________________________

8. Has this case been investigated or reviewed by any state board? ☐ No ☐ Yes ☐ Pending

   If Yes or Pending, name of Licensing Board: ______________________________________

   What was the outcome? Please include a copy of the Licensing Board's final disposition:

   ____

9. On a separate sheet of paper, in your own words, **describe the claim / suit** and your involvement. Attaching the NPDB description is not an acceptable response.

10. **Attach the following documents to this form**. Your application will not be decided upon until the following attachments have been received:
    a. plaintiff's complaint or claim to insurer;
    b. settlement agreement, court order or dismissal letter (if case has concluded) and
    c. Board resolution after investigation of case (if case has concluded).

______________________________________ ______________________
Signature of applicant Date signed

Completed form and documentation may be faxed to Board office at 480-657-7715

License Application Checklist

License Application packets with original notarized signatures must be mailed or delivered to the Board office.
Scanned or faxed license applications are not acceptable.

A. Before you send us your application packet, please make certain you have completed the following.

☐ 1.	A current version of the Board's license application downloaded from www.azdo.gov.
☐ 2.	All sections of the four page application are filled in with correct information OR marked N/A if not applicable.
☐ 3.	A clear passport type color picture of you (2" x 2") taken within the past 60 days attached to the front page of the application. We prefer you use transparent tape around the edges because your application packet will be scanned.
☐ 4.	Your name, date and notarized signature in Section 11 of the application. DO NOT LEAVE ANY QUESTION UNANSWERED IN THE APPLICATION OR ANY FIELD IN THE OATH AND NOTARIAL CERTIFICATE BLANK.
☐ 5.	Photocopy of a current valid government issued photo ID. For example, a driver's license, U.S. Passport or military ID.
☐ 6.	Copy of court records of any name changes, if applicable.
☐ 7.	Explanations and supporting documentation of all "yes" answers to Professional Conduct History. This includes medical malpractice settlements, etc. Use the form "Malpractice Claim/Suit Questionnaire" as a coversheet for each instance of medical malpractice.
☐ 8.	Copy of AOA-BOS or ABMS specialty certification or letter verifying specialty and/or subspecialty, dates of issuance and expiration, if applicable.
☐ 9.	Completed Citizenship/Alien status two page form signed in section IV.
☐ 10.	Photocopy of current U.S. passport, birth certificate or a legible copy of one or more document(s) from the "Evidence of U.S. Citizenship, U.S. National Status or Alien Status" page included in this packet.
☐ 11.	Copy of your osteopathic diploma. This may be a digital photo of your framed certificate sent by email.
☐ 12.	Copies of your PGT certificates, as applicable. This may be a digital photo of your framed certificate sent by email.
☐ 13.	$400 application fee. The fee can be paid by Visa, MasterCard, American Express, check or money order. This fee is for processing the application only and is non-refundable.

B. It is your responsibility to make certain the following Verifications are sent directly to the Board.

☐ 14.	Verification of graduation from college/school of osteopathic medicine (Form No. 1).
☐ 15.	Verification of all postgraduate training regardless of completion (Form No. 2).
☐ 16.	Original transcript of your medical licensure examination scores, if applicable. Contact NBOME or NBME for its requirements to have an original transcript sent to the Arizona Osteopathic Board.
☐ 17.	Verification of state licensure and professional conduct history, if applicable. Contact each state board for its requirements. Boards may require payment of a fee for this service.
☐ 18.	Verification of practice experience (Form No. 3). This is for each facility at which you practiced medicine or for whom you practiced medicine in the last seven (7) years, or the last ten (10) years if a gap of more than a year exists in your practice history.

C. Fingerprint Packet – You will be sent a fingerprint packet after your application has been received by the Board.

☐ 19.	Applicants for licensure are required to undergo a background check. Follow the instructions in the packet. Fingerprint cards cannot be accepted prior to the license application. No fingerprint fee is required at this time.

You do not need to include this checklist with your application. Its purpose is to help you complete the paperwork associated with licensure and submit a satisfactory application which will prevent any unnecessary delays.

Questions? Please call the licensing division at 602-771-2525
or email your question(s) to Questions@AZDO.gov

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 | questions@azdo.gov

CREDIT CARD PAYMENT AUTHORIZATION

Name of Applicant: ____, D.O.

If paying by credit card, complete and return this form and mail with your application.
You may also pay with check or money order.

Application Fee: $400.00

Type of Card: ☐ **Visa** ☐ **MasterCard** ☐ **American Express**

Visa or MasterCard #: _____________ - _____________ - _____________ - _____________

OR

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***

Application Processing Overview

YOU HAVE SUBMITTED YOUR APPLICATION, WHAT HAPPENS NEXT?

EMAIL ACKNOWLEDGEMENT: When Board staff has received your application packet, you will be sent an email acknowledging receipt. If you do not provide an email address, no acknowledgement will be sent. This acknowledgement does not mean that all required documents have been received.

FINGERPRINT PACKET: As of September 1, 2017, initial license applicants are required to undergo fingerprinting per A.R.S. § 32-1822(A)(9). A fingerprint packet will be sent to you at the mailing address you provided on your license application. Follow the instructions in the fingerprint packet to avoid delays or having to repeat submission of your fingerprints. Your application will remain administratively incomplete until all required documentation has been received including fingerprint processing.

ADMINISTRATIVE COMPLETENESS/DEFICIENCY LETTER: Within 30 days after sending the acknowledgement email, staff will mail a letter to you listing the missing or incomplete information needed to complete your application. This will include the date we received your license application. Your application remains open for 360 days from this date. If all required documents and verifications are not received within 360 days, your application will expire. The fee is non-refundable.

ADMINISTRATIVELY COMPLETE: After everything in the License Application Checklist has been received, the Board staff will independently obtain the following:

1. National Practitioner Data Bank report
2. Federation of State Medical Board's Practitioner Profile

At this point your application is administratively complete and moves to substantive review.

SUBSTANTIVE REVIEW: This stage of the application process is the evaluation of all answers, documents and verifications collected, and the decision whether they demonstrate you are qualified for licensure in Arizona. This process is conducted by the Executive Director and may take 1 – 90 days. You may be required to appear before the Board at a regularly scheduled Board meeting for a decision on your application.

ISSUANCE OF LICENSE: If at the conclusion of the substantive review your license is approved, you will receive a letter of congratulations and an invitation to request issuance your license. At this point your license is approved but has not been issued and you cannot yet practice medicine in Arizona.

Enclosed with the approval letter is the **Request for Issuance of License** form. To have your Arizona license activated, please complete this form, sign and date it and submit it with the license issuance fee. We will accept scanned or faxed copies of this form if accompanied by the credit card payment form included with the letter or you can submit the form and fee by check or money order via mail or delivery service.

You have 90 days from the approval date to accept and pay for your license. We cannot accept issuance requests in advance. There is a prorated fee table on the issuance form. Your credit card will be charged the applicable month's fee for the date the license is issued. Your license effective date will be the date we receive your issuance request form and fee.

You can check on the status of your license after it is issued by going to www.azdo.gov > Doctor Search and performing a license search on your last name. Your web profile only appears after the license is issued and will be your proof of licensure.

MAINTAINING YOUR LICENSE: Your initial license will be valid until the end of the calendar year in which it is issued. Please see the License Renewal and CME FAQ on our website at www.azdo.gov for more information regarding maintaining and renewing your Arizona license.

Arizona Revised Statutes and Rules for osteopathic licensure can be found on our website at www.azdo.gov > Statute and Rules. As a licensed physician you will be subject to all state and local laws and regulations pertaining to public health and subject to all the same duties and obligations and authorized to exercise all the same rights and privileges possessed by physicians and surgeons of other complete schools of medicine in the practice of their profession per A.R.S. § 32-1852.

ASU SURVEY

The Arizona State University Center for Health Information and Research with the Arizona Board of Medicine and the Arizona Board of Osteopathic Examiners in Medicine and Surgery conducts this survey to gather information on the factors that influence physicians to practice in Arizona. **Your participation is voluntary and your responses are confidential. The data is stored in a secure facility at Arizona State University and only aggregate results are published.**

Applicant Name____, D.O.

1. I am applying for an Arizona license because (check the **most important** reason)

☐ Completed residency, entering practice
☐ Beginning fellowship in Arizona
☐ Completing fellowship in another state
☐ Federal physician transitioning to private practice
☐ Transfer by corporate employer health insurer
☐ Locum tenens
☐ To treat Arizona patients via Telemedicine
☐ Other (Specify) _________________________________
☐ Bought into a practice/partnership in Arizona
☐ Accepted hospitalist position in Arizona
☐ Joint job change with spouse/significant other
☐ Bad malpractice climate
☐ Poor reimbursement
☐ To do utilization review on Arizona patients
☐ Managed care penetration

2. I am **moving to** (city/town)____________________Arizona **from** (city/town)_______________________State______

3. How did you learn of the position that you accepted in Arizona:

☐ Recruited by hospital/university
☐ Recruited by professional acquaintances
☐ Through a search firm
☐ Through an ad in a journal/professional publication
☐ Through information obtained during residency/fellowship
☐ Other____

4. Please select, from the following list**, <u>up to three</u>** of the important influences on your decision to practice in Arizona rather than in some other state.

☐ Family/personal ties
☐ Job opportunity for spouse/significant other
☐ Climate
☐ Lack of positions in chosen field in other states
☐ Quality of elementary/secondary schools
☐ Compensation/cost of living
☐ National Service Corp obligation
☐ Quality and availability of emergency facilities
☐ Availability of specialists for consultation
☐ Relatively low malpractice premiums

☐ If other important factor, specify____

____

5. If your new position includes treating patients, do you plan to accept: *Medicare* ☐ Yes ☐ No *Medicaid* ☐ Yes ☐ No

6. Can you converse, without a translator, to patients who speak the following as their only language? **(Check all that apply):**

English	Spanish	French	Chinese	Vietnamese
☐	☐	☐	☐	☐
Arabic	Tagalog	Other:		
☐	☐	☐	_________________	

7. Did you use electronic medical records in your last practice setting? ☐ Yes ☐ No

8. Do you expect to use electronic medical records in your new practice setting ☐ Yes ☐ No ☐ Don't Know

THANK YOU FOR TAKING THE TIME TO HELP PLAN FOR THE FUTURE PHYSICIAN WORKFORCE