Arizona Board of Osteopathic Examiners In Medicine and Surgery
9535 E. Doubletree Ranch Road, Scottsdale, AZ 85258
Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

LOCUM TENENS REGISTRATION APPLICATION

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

Fee: $300.00

This application is in accordance with A.R.S. § 32-1823. The filing of this application does not grant any special privilege to open an office or to conduct any method of treating the sick or afflicted in the State of Arizona nor does it imply or guarantee that a regular license to practice osteopathic medicine and surgery in Arizona will be granted upon application.

If approved, the Locum Tenens registration certificate will be mailed to the sponsoring physician.

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.

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
Email Address national medical exam scores, Check here: ☐

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: SPONSORING ARIZONA LICENSED PHYSICIAN

In addition to providing the information below, the sponsoring physician (M.D. or D.O.) must submit a written request pursuant to A.R.S. § 32-1823(A)(2) which includes the required information as stated in the LT application instructions. To facilitate this request a form has been provided in the application packet (Sponsoring Physician: Written Request for Locum Tenens Registration).

Name of Sponsoring Physician:	
Name of Company/Practice:	
Address:	
City, State, Zip:	Phone Number:
Exact Requested Dates of Locum Tenens (not longer than 90 days): Start Date: _____ End Date: _____	

SECTION 4: EDUCATION AND TRAINING HISTORY

Fill in the areas below completely and accurately. Please submit Form No. 1 to the Osteopathic College from which you graduated and Form No. 2 to all program(s) at which you trained, regardless of completion. The form must be completed by the Program Director and returned directly to the Arizona Board of Osteopathic Examiners in order to provide verification of your training. If the facilities are now defunct, please so indicate. If more space is needed, use a separate sheet.

	Name of Institution	City/State	Years Attended From/ To
Osteopathic College			
Internship/PGY-1			
Residency			
Residency (if more than one)			
Fellowship			

SECTION 5: NATIONAL MEDICAL EXAMINATION

List the national medical examinations you passed and dates. If you passed Level 3 of the COMLEX or Part 3 of the USMLE exam in the past seven (7) years, you must provide proof you passed the exam as listed in the instructions. If it has been more than seven (7) years since you passed your licensing examinations, you do not need to provide proof. However, you still need to list the exams you passed in the table below:

Name of Exam / Part or level	Date passed

SECTION 6: STATE LICENSES

Fill in the information for each license you hold or have held. If you were previously licensed in Arizona, provide that information also. Please use a separate blank sheet of paper if necessary to provide a complete list. Explain any time you were not in practice. You must request that each state listed (except Arizona) send a verification of license directly to the Arizona Board of Osteopathic Examiners.

Issuing State	License Number	Issue Date: MM/DD/YY	Expiration Date: MM/DD/YY	License Status

SECTION 7: FIELD OF PRACTICE/AREA OF INTEREST: _____

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.

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 of your locum tenens registration.

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 have 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 at least one year 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 less than one year 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.

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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Form No. 1: PROFESSIONAL EDUCATION VERIFICATION

In applying for a locum tenens registration 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, 9535 East Doubletree Ranch Road, Scottsdale, Arizona 85258**.

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

Arizona Board of Osteopathic Examiners In Medicine and Surgery
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Form No. 2: POSTGRADUATE TRAINING VERIFICATION

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 locum tenens registration 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 a locum tenens registration 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** ○

---

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

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Form No. 3: PRACTICE EXPERIENCE VERIFICATION

In applying for a locum tenens registration 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 ***DIRECTLY*** to the Arizona Board of Osteopathic Examiners, 9535 East Doubletree Ranch Road, Scottsdale, AZ 85258.

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: _____ Phone No: _____

Address: _____ Fax No.: _____

City/State/Zip: _____ Email: _____

Name of Official (printed): _____ Title: _____

Signature: _____ Date: _____

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

Arizona Board of Osteopathic Examiners LT Registration 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 Board: _____

   What was the outcome? Please include a copy of the final disposition:

   _____

9. On a separate sheet of paper, in your own words, **briefly describe the claim / suit** and your involvement. Attaching the NPDB description is <u>not</u> 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

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Sponsoring Physician: Written Request for Locum Tenens Registration

To be completed by the Arizona licensed doctor of osteopathic medicine (D.O.) or doctor of medicine (M.D.) requesting locum tenens registration of the applicant in accordance with A.R.S. § 32-1823.

1. Name of Locum Tenens Applicant: _____, D.O.

2. Applicant will be providing locum tenens medical services to (check one):

   ☐ **SUBSTITUTE FOR** the sponsoring physician

   ☐ **TEMPORARILY ASSIST** the sponsoring physician

3. Exact Start Date for which Locum Tenens is requested: _____ (month, day, year)

   Granted Locum Tenens registration is valid for ninety (90) days and may be extended once for an additional ninety (90) days upon written request from the sponsoring physician who originally initiated the request for this registration. The written request must state the reason for the extension. Submit the appropriate fees and other documents requested by the Executive Director.

4. Name of Sponsoring Physician (print): _____ Arizona License No.: _____

5. Sponsoring Physician Contact Information:

Name of Practice	
Address	
Address	
City, State and Zip	
Phone Number	
Fax Number	

6. _____ D.O. M.D. Date: _____
   Signature of Arizona Licensed Sponsoring Physician (circle one)

90-Day Locum Tenens (LT) Registration Application Checklist

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

BEFORE YOU SEND US YOUR LOCUM TENENS REGISTRATION APPLICATION PACKET, CHECK THAT YOU HAVE COMPLETED THE FOLLOWING:

- ☐ 1. A completed and notarized current version of the Board's registration application. Please download the current version from our website at www.azdo.gov > For DOs > New License Application.
- ☐ 2. $300 application fee. We accept Visa, MasterCard, American Express check or money order. If paying by credit card, please use the credit card payment form included in the application packet. Make your check or money order payable to the Arizona Board of Osteopathic Examiners .
- ☐ 3. Written request from the sponsoring M.D. or D.O. licensed in Arizona for whom you are substituting or assisting (see instructions for details).
- ☐ 4. Copy of government issued picture ID (e.g., current driver's license or US passport) showing same name as used on application.
- ☐ 5. Completed Arizona Statement of Citizenship Status form and copy of government issued documentation showing citizenship or resident alien status (e.g., current US passport, birth certificate, naturalization certificate, green card, etc.).
- ☐ 6. Copy of legal documentation showing change of name, if applicable.
- ☐ 7. Explanations and supporting documentation of all "yes" answers to Professional Conduct History questions. 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 your diploma or transcript from an approved College of Osteopathic Medicine (COM) showing the date of your graduation. Sent Form No. 1 to your COM for verification.
- ☐ 9. Copy of certificate or official letter showing completion of your internship or first year of residency. Sent Form No. 2 to all programs at which you trained, regardless of completion.
- ☐ 10. Proof that you passed the national osteopathic medical examination(s).
- ☐ 11. Sent Form No. 3 to all facilities where you practiced medicine in the last seven (7) years for verification.
- ☐ 12. Requested verification of licensure and disciplinary history from each state in which you are or have been licensed be sent to the Arizona Board of Osteopathic Examiners.

Do not include this checklist with your application. Its purpose is to help you complete the paperwork associated with licensure and submit a satisfactory application, thereby preventing unnecessary delays.

Please call or email with any questions
480-657-7703

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CREDIT CARD PAYMENT AUTHORIZATION FOR OSTEOPATHIC LOCUM TENENS REGISTRATION APPLICATION FEE

Name of Applicant: _____, D.O.

Please complete and mail with your application if paying by credit card.

Amount: $300.00

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

Locum Tenens Registration 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.

ADMINISTRATIVELY COMPLETE/DEFICIENCY LETTER: Within thirty (30) days after receipt of the application, staff will mail a letter to you listing the missing or incomplete information needed to complete your application.

If all the documents on the checklist have been received, you will not receive this letter.

ADMINISTRATIVELY COMPLETE: After everything on the 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 the locum tenens registration. You may be required to appear before the Board at a regularly scheduled Board meeting for a decision on your application.

ISSUANCE OF LOCUM TENENS REGISTRATION: If, at the conclusion of the substantive review, your application is approved, you will receive a letter by email and regular mail letting you know your Locum Tenens Registration has been issued. Your registration number, effective date, and expiration date are also provided. Included with the letter is a copy of the issuance letter and registration certificate sent to your sponsoring physician.

As of the effective date of registration you may assist or substitute for the sponsoring physician. A Locum Tenens Registration does not authorize you to practice medicine independently in Arizona. If you want to practice in Arizona at a facility or location other than your sponsoring physician's practice location(s), you will need to obtain full licensure.

If your sponsoring physician wants you to continue assisting or substituting for him/her after the expiration date, the sponsoring physician must send a written request stating the reason for the extension. Another $300 fee must be paid in order to extend the registration for another 90 days. This request may be sent to the Board office by fax, email, or regular mail.

Arizona Revised Statutes and Rules for osteopathic licensure can be found on our website at www.azdo.gov > Statute and Rules. As a Locum Tenens registered 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.