Permit Number: _____ Issued Date: _____ Effective Date: _____ End Date: _____

(For Board Use Only - Do Not Write Above This Line)

ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY
1740 W. Adams Street, Suite 2410
Phoenix, AZ 85007
PH: 480-657-7703 | FX: 480-657-7715
www.azdo.gov | questions@azdo.gov

FOR BOARD USE ONLY

ARIZONA OSTEOPATHIC POSTGRADUATE TRAINING PERMIT APPLICATION (Internship-Residency-Fellowship)

Fee: $50.00 per Permit

For new D.O. trainees who do not currently have an active permit for the program listed in Section 1 or whose permit has expired. If you currently hold an active permit, please use the OSTEOPATHIC POSTGRADUATE TRAINING RENEWAL APPLICATION form.

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: TO BE COMPLETED BY NEW APPLICANTS

A. IDENTIFICATION and CONTACT NFORMATION

Applicant Name (Last, First, Middle): _____

Other names used: _____
Attach copies of all legal documentation showing name changes (i.e.: marriage certificate, divorce decree)

Date of Birth (Required): _____ SSN (Required): _____

Residential address while in Arizona OR current address:

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email (required): _____

B. ARIZONA PROGRAM INFORMATION

Name of Training Program/Facility: _____

Primary Specialty Field: _____

This is an: ☐ Internship ☐ Residency ☐ Fellowship

C. EDUCATION HISTORY

You must submit Form No. 1 to your Osteopathic College for verification.

College of Osteopathic Medicine (COM) from which you graduated:

COM Name: _____

City/State: _____

Graduation Date: (MM/DD/YYYY) _____/_____/_____

D. NATIONAL MEDICAL EXAMS

List the national medical examinations you passed and dates. You must submit either a photocopy or original transcript of your COMLEX Score Report to date and/or USMLE Score Report, or a legible print screen of your View Scores page from NBOME's website.

Name of Exam / Part or Level	Date Passed

E. POSTGRADUATE TRAINING HISTORY

In the box below, please list the internship and residency program(s) in which you have participated, regardless of completion (if any). You must submit Form No. 2 to each program for verification.

1.	Program Name:	Complete Address:	
	Specialty Area:	Start Date: (mm/dd/yyyy)	End Date: (mm/dd/yyyy)

2.	Program Name:	Complete Address:	
	Specialty Area:	Start Date: (mm/dd/yyyy)	End Date: (mm/dd/yyyy)

3.	Program Name:	Complete Address:	
	Specialty Area:	Start Date: (mm/dd/yyyy)	End Date: (mm/dd/yyyy)

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D.O. POSTGRADUATE TRAINING PROFESSIONAL CONDUCT HISTORY QUESTIONNAIRE

Applicant Full Name: _____

Name of Program/Facility & Specialty: _____

&. PROFESSIONAL CONDUCT HISTORY (to be completed by applicant)

FAILURE TO PROPERLY ANSWER THE QUESTIONS BELOW MAY RESULT IN BOARD DISCIPLINARY ACTION OR DENIAL.

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?		

'. 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.		

I declare and attest that I am the applicant and the person named in this application and in all materials submitted in support of this application, that all facts stated herein as well as any facts stated on any separate sheets attached hereto are true, complete and correct. I understand any misrepresentation, including omission of information, may result in an unprofessional conduct action against this permit or any subsequent application for licensure.

Applicant's Signature: _____ Date:_____

SECTION 2: TO BE COMPLETED BY PROGRAM DIRECTOR

Section 2A must be completed by your program director.

INTERNSHIP-RESIDENCY-FELLOWSHIP PROGRAM CERTIFICATION

A. Full Name of Training Program: _____

Address: _____

Address: _____

City _____ State _____ Zip _____

Phone Number: _____ Email Address: _____

Program Accredited by: ☐ AOA ☐ ACGME ☐ Dual Program No.: _____

This is an: ☐ Internship ☐ Residency ☐ Fellowship

Primary Field: _____

This application for permit is for (dates): _____/_____/_____ to _____/_____/_____ (one year maximum.)

Please list the hospitals/facilities at which this intern, resident, or fellow will be working in Arizona:

1. _____ 3. _____

2. _____ 4. _____

Name Signed: _____ Date: _____

Name Printed: _____ Title: _____

B. Rotation Applicants Only: Have the accredited Arizona hospital/program where you are doing your rotation complete this section.

ARIZONA CERTIFICATION FOR DOCTORS FROM OUT-OF-STATE PROGRAMS

TO BE COMPLETED BY ARIZONA HOSPITAL/PROGRAM PERSONNEL:

Contact Name: _____

Name and Address of Hospital/Program: _____

_____

Phone Number: _____

Email Address: _____

Program Accredited by: ☐ AOA ☐ ACGME ☐ Dual Program No.: _____

Authorizing Signature: _____

Name Printed: _____ Title: _____

Date of Rotation From: _____ / _____ / _____ to _____ / _____ / _____

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Form No. 1: PROFESSIONAL EDUCATION VERIFICATION

In applying for a PGT permit 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 St., Ste 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 College of Osteopathic of Medicine (COM))

_____
(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 DIRECTLY TO THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS
Completed form may be emailed or faxed with coversheet to the Board office

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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 when applying for a postgraduate training permit 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 postgraduate training permit 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

Completed form may be emailed or faxed with coversheet to the Board office

Arizona Board of Osteopathic Examiners Postgraduate Training 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 Practitioner Data Bank, OR if you have been notified that any such suit or claim is pending. Duplicate this form as necessary.

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 all of the following documents 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

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

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). A birth certificate must be accompanied by a copy of a current government issued ID.

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.

Arizona Board of Osteopathic Examiners In Medicine and Surgery
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CREDIT CARD PAYMENT FORM

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

Item/Service Requested:_____ Amount $ _____

We do not accept credit card information by fax or email. Payment can be mailed or called in over the phone.

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***

Postgraduate Training Permit Application
Processing Overview

YOU OR YOUR RESIDENCY COORDINATOR SUBMITTED YOUR POSTGRADUATE TRAINING PERMIT APPLICATION, WHAT HAPPENS NEXT?

ADMINISTRATIVE COMPLETENESS/DEFICIENCY LETTER: Within about fourteen (14) days after your application has been received, staff will email you a list of the missing or incomplete documentation needed to complete your application. Your residency coordinator will be copied on the email. However, you are responsible to submit the verification forms to your College of Osteopathic Medicine and any postgraduate training programs in which you have participated regardless of completion. This does not include an academic year you have not yet started. Contact your residency coordinator if you need assistance. You may also email or call the Board's licensing division.

If all the documents needed to complete your application have been received, you will not receive an email.

ADMINISTRATIVELY COMPLETE: Your application is complete when all the required documentation has been received at the Board's office. At this point your application 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 a postgraduate training permit. You may be required to appear before the Board at a regularly scheduled Board meeting for a decision on your application.

ISSUANCE OF YOUR PERMIT: If at the conclusion of the substantive review your permit is approved, it will be issued within three (3) business days. A letter will be sent by email to your residency coordinator. This letter provides your permit number, your name and the effective dates of the permit along with other important information. It may also list other residents in your program. You will be copied on the email, or if the letter has more than one resident listed you will be blind-copied.

You can check on the status of your permit the Friday after it is issued by going to www.azdo.gov > For DOs > Postgraduate Permits and clicking on the permit list for the newest academic year listed. If a permit is issued late on Thursday or on Friday, the list on the website will not show your permit until the following Friday afternoon.

RENEWING YOUR PERMIT: Unless you are doing a short rotation of four (4) months or less, your permit is valid for one year and must be renewed each year you are enrolled in an Arizona postgraduate training program.

In most instances, your residency coordinator will register you for renewal online starting March 1 of each year. However, you will have some paperwork to fill out to complete the process. If your residency coordinator has not provided you with the document(s) you need to complete for your renewal, please contact him/her at least sixty (60) days in advance of your next academic year's start date. You may also contact the Board's licensing division for assistance.

Arizona Revised Statutes and Rules for osteopathic licensure can be found on our website at www.azdo.gov > Statute and Rules. As a permit holder in the supervised setting of your accredited postgraduate training program, 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.