Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 W. Adams Street, Suite 2410, Phoenix, Arizona, 85007
Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

OSTEOPATHIC POSTGRADUATE TRAINING PERMIT RENEWAL APPLICATION

Fee: $50.00 per Permit

Complete all sections. If your application is incomplete, it may cause a delay in renewing your permit. Submit your completed form and applicable documentation to your residency coordinator.

Please use the name change request form on our website at www.azdo.gov to report a change of name.

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.

A. CONTACT INFORMATION: Your residential address, phone and email address are confidential.

Applicant Name: _____ **Phone**: _____

Arizona Residential Address: _____

City, State and Zip: _____

Email Address: _____

B. PROGRAM INFORMATION: Please list your training program or facility name, the specialty in which you are training and the start and end dates of your training for the next academic year. These are the dates for which your renewed permit will be effective, contingent upon approval of an administratively complete application. If you do not know the exact dates, please check with your residency program coordinator.

PGT Training Program/Facility: _____

Training Specialty: _____ **Permit No.:** _____

Training Start Date : _____ **Expected End Date**: _____
MM / DD / YYYY MM / DD / YYYY

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PHYSICIAN'S NAME: _____ **PERMIT NO.** _____

PGT PROGRAM/FACILITY: _____

TRAINING SPECIALITY: _____

C. PROFESSIONAL CONDUCT HISTORY QUESTIONNAIRE

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?		

D. 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 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.		

E. *I 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**:_____

Submit your completed form and applicable documentation to your residency coordinator.

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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***