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

ARIZONA D.O. PUBLIC RECORDS REQUEST FORM

To order, please complete this form and mail, email or fax to the Arizona Board of Osteopathic Examiners in Medicine and Surgery. If paying by check, you will be invoiced for the cost of the copies. Upon receipt of your check or credit card payment form, the requested documents will be forwarded. If paying by credit card, please complete the attached Credit Card Payment Form and mail, email or fax it to the Board. A receipt for the total amount charged will be sent with the documents requested.

Contact Name (please print) Phone Number

Company Name Fax Number

Address

City/State/Zip

Public Records Requested

PLEASE NOTE: All investigative materials (case files) are confidential and will not be made available to the public. Only the final disposition of a case is public information. Disciplinary actions from the last two (2) years are available for free download at www.azdo.gov in the Recent Board Actions list. All disciplinary actions are available for free download in the physician's online professional profile (use Doctor Search). Non-disciplinary actions for the past five (5) years are available upon written request by email. Please send your request to questions@azdo.gov. Letters of Concern and Dismissals are no longer part of the public record after five (5) years from date of issuance. Minutes for the past five (5) years are available for free download at www.azdo.gov. Please see the Public Records Request Notice for further information regarding what is and what is not public record.

License Files – List physician's full name or license number if known.	
Board Meeting Minutes – List meeting dates.	

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I want to view public records at the Arizona Board of Osteopathic Examiners in Medicine and Surgery's office at no cost.
I will arrive between ☐ 8 am-Noon ☐ Noon-5pm on date: _____

☐ I want to purchase copies of the public records. Copied documents will be emailed to you in PDF format. Copies are $0.25 per page.
REQUIRED: Email address for data transfer: _____

Pursuant to A.R.S. § 39-121.03, please complete the following statement:

These records will be used for ☐ commercial purposes. ☐ non-commercial purposes.

If commercial purpose, you are required to specifically state for what purpose: _____

_____

The public records described above and which I have requested are to be used solely for the purposes stated above. They will not be used directly or indirectly for a different purpose other than described above. The information I have provided is true and correct.

_____ _____
Authorized Signature Date

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CREDIT CARD PAYMENT FORM

Name of Physician_____ Date _____
(if applicable)

Item/Service Requested: _____

This form and your order/application may be faxed to: 480-657-7715
If faxing this form, please do not mail the original as you may be charged twice.

Amount: $_____

Type of Card: ☐ Visa ☐ MasterCard ☐ American Express

Visa or MasterCard #: _____ - _____ - _____ - _____

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***