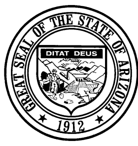


Arizona Medical Board
Arizona Regulatory Board of Physician Assistants

LICENSE VERIFICATION REQUEST FORM

Please complete and submit this form, along **with payment**, to request a license verification (sometimes called a letter of good standing) be sent to another regulatory board or other organization.

Licensee Name: ______________________________ **Licensee Date of Birth** (if known): ___________________

License # (if known):___________________________

Requestor's Name (if different than licensee): ____
Requestor's Address: ____
____
Contact Telephone Number for Requestor: (In case there are questions pertaining to your request): ____________

Type of Arizona License to be Verified:
- ☐ **M.D.**
- ☐ **M.D. Resident/Post-Graduate Training**
- ☐ **M.D. Pro Bono**
- ☐ **M.D. Locum Tenens**
- ☐ **P.A.**
- ☐ **P.A. Temporary**
- ☐ **Other (specify):____________________________**

NOTE: If more than one type of license must be verified, more than one fee must be paid. For example, if both a regular M.D. and a Locum Tenens license must be verified, a fee of 20.00 must be paid ($10.00 for each verification).

Name of the Board/Organization to which the Verification is to be sent:____________________________________

How would you like the verification to be sent to the Board/Organization (choose one):

☐ **Mailed: Please complete the following**: **Address of Board/Organization**:
____
____
____
Attn: ____

☐ **Faxed: Please complete the following:** **Fax # of Board/Organization**: ______________________
Prior to selecting the fax option, please contact the board/organization to whom you are having the verification sent, to ensure they will accept a faxed verification.

☐ **Other**: _____________

NOTE: If delivery via FedEx, UPS, DSL, or a similar company is requested, an envelope and pre-completed waybill, including the requestor's account number for payment, must be provided with this request form.

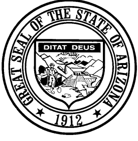
Payment Method: (There is a $10.00 fee for each verification sent)
- ☐ **Check** (Must be enclosed with this form - make checks payable to Arizona Medical Board)
- ☐ **Credit Card** (The credit card payment form accompanying this document must be completed & returned)

NOTE: If payment does not accompany this form, the verification request will not be processed, and will be returned to the requestor.

Please mail or fax the written license verification request to:

Arizona Medical Board
Attn: Amanda Schwabe, Public Records Coordinator
9545 E. Doubletree Ranch Rd. Scottsdale, AZ 85258
FAX: (480) 551-2707

NOTE: THE ARIZONA MEDICAL BOARD IS NOT RESPONSIBLE FOR VERIFICATIONS THAT HAVE BEEN PROCESSED AND SENT, BUT NOT RECEIVED BY THE INTENDED RECIPIENT. THERE IS A $10.00 FEE FOR VERIFICATIONS WHICH MUST BE RE-SENT. A METHOD OF DELIVERY WHICH PROVIDES TRACKING SERVICE, SUCH AS FEDEX, UPS, DSL, ETC., IS RECOMMENDED TO ENSURE THE RECIPIENT'S RECEIPT OF THE VERIFICATION.



Arizona Medical Board
Arizona Regulatory Board of Physician Assistants

PAYMENT CARD AUTHORIZATION

Payment for: ______________________________ **MD Lic #** ______________
Physician Name

LICENSE VERIFICATION $10.00

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

Card #: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiration Date: ☐☐-☐☐ **(MM-YY)**

Name as Shown on Payment Card: ______________________________

Billing Address of Cardholder:
(Required)

Street Address: ______________________________
City: ______________ **State:** ______________ **Zip:** ______________

Phone Number of Cardholder: ______________
(Required)

Mailing Address of Cardholder: (If different from billing address):

Street Address: ______________________________
City: ______________ **State:** ______________ **Zip:** ______________

Signature of Cardholder: ______________________________ **Date:** ______________

Please complete and return this form *with your verification request if paying by payment card.*
Fax to: 480-551-2707 or
Mail to: Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258