



## ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258

Telephone (480) 551-2700 • Fax (480) 551-2704

Website: <http://www.azmd.gov> or E-Mail: [questions@azmd.gov](mailto:questions@azmd.gov)

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### APPLICATION for TEACHING LICENSE in the STATE of ARIZONA

#### INFORMATION

A board approved school of medicine in this state or a teaching hospital's accredited graduate medical education program in this state may invite a doctor of medicine to provide and promote professional education through lectures, clinics or demonstrations. The doctor of medicine is prohibited from opening an office or designating a place to meet patients or receive calls relating to the practice of medicine in this state outside of the facilities and programs of the approved school or teaching hospital.

To receive a teaching license, the doctor of medicine shall:

1. Complete an application as prescribed by the board.
2. Pay all required fees.
3. Meet the basic requirements of the Arizona Revised Statute section 32-1422 except for those relating to completing an approved hospital internship, residency or clinical fellowship program.

A teaching license is limited to a one year period. The doctor of medicine may reapply annually for no more than a total of four years. With each reapplication the doctor of medicine must submit all required fees and a petition from the school or teaching hospital asking the board for continuation of the teaching license.

The holder of a teaching license is not exempt from the requirements of the Arizona Revised Statutes and rules with the exception of the training and examination requirements.

A doctor of medicine holding a current teaching license at an approved school of medicine may convert that license into an active license by filing an application and meeting all applicable requirements.

#### APPLICATION INSTRUCTIONS (Read Carefully)

In addition to the appropriate completion of the applicable sections of this application, the applicant will submit the following:

1. Evidence of name and date of birth: a copy of U.S. birth certificate, U.S. passport, Permanent resident card, naturalization certificate or visa. (Do not submit originals.)
2. Evidence of any legal name changes other than that shown on certificates filed in accordance with paragraph 1 above, i.e, marriage license or official name change through the court.
3. Copy of M.D. degree diploma.
4. Copy of all internship, residency or fellowship certificates.
5. Copy of ECFMG certificate, if applicable.
6. Check, Money Order or Payment Card authorization form (see attached) for the nonrefundable fee in the amount of \$250 (US dollars only). Applications submitted without the fee will not be processed.
7. Home address, telephone number, social security number and date of birth. (This information will remain confidential.)
  - Credentials submitted in foreign languages shall have affixed thereto a certified translation into English.
  - Requests for exemptions or waivers of any portion of this application will be denied and will delay your consideration for licensure.
  - All credentials submitted become the property of the Arizona Medical Board and *will not* be returned.
  - Photocopies shall not exceed 8 ½ inches by 11 inches in size.
  - If paying by Payment Card Authorization, the application and documents may be faxed to 480-551-2704.

# APPLICATION

Official Use Only: Inquiry # \_\_\_\_\_

Date Application Received \_\_\_\_\_

(To be completed and signed by applicant. All questions MUST be answered, even if only to indicate "None" or "N/A".)

1. Present Name \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)

(a) Other names used: \_\_\_\_\_

2. Office/Training Address: \_\_\_\_\_  
(No.) (Street) (City) (State) (Zip/Post Code)

3. All States or provinces in which you **have or had** a license or registration. If more than five, attach separate listing. If license is pending or was not issued, so state. If none, please indicate by stating "Not Applicable."

(a) \_\_\_\_\_  
(State Board) (License No.) (Status of License, i.e., expired, active, etc.)

(b) \_\_\_\_\_  
(State Board) (License No.) (Status of License, i.e., expired, active, etc.)

(c) \_\_\_\_\_  
(State Board) (License No.) (Status of License, i.e., expired, active, etc.)

(d) \_\_\_\_\_  
(State Board) (License No.) (Status of License, i.e., expired, active, etc.)

(e) \_\_\_\_\_  
(State Board) (License No.) (Status of License, i.e., expired, active, etc.)

4. Medical School Name: \_\_\_\_\_

Medical School Location: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_  
Month/Day/Year

If you graduated from a medical school located outside the United States of America or Canada please list below:

ECFMG # \_\_\_\_\_ Certificate Date: \_\_\_\_\_  
Month/Day/Year

5. List chronologically, all Internship, Residency and Fellowship training in U.S. or Canada (**COMPLETED OR NOT**), or Assistant Professorship (or higher) at any programs attended, showing institution, address, type of program and dates. Attach separate listing if needed.

INSTITUTION NAME	CITY/STATE	TYPE OF PROGRAM/PGY YEAR	DATES OF ATTENDANCE



10. Have you ever had any application for any professional license refused or denied by any licensing authority?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
11. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
12. Have you ever been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
13. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
14. Have you ever voluntarily surrendered any healthcare license?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
15. Have you ever had any healthcare license revoked?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
16. Have you ever been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
17. Have your privileges ever been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
18. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
19. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
20. Have you ever had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
21. Have you ever been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) <b>A “yes” answer is required even if you entered a diversion program.</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
22. Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
23. In the last ten (10) years has a judgment or settlement been entered against you as a defendant in a medical malpractice suit? <b>*Please <u>do not</u> report <u>pending malpractice suits or settlements paid not related to a civil action.</u></b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
24. Have you ever been court martialled or discharged other than honorably from the armed service?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
25. Have you ever been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
26. Have you ever been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

**Note: *In the event the response to any of the questions numbered 10 through 26 is “YES”, the applicant must file with the application a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such charge(s). IN ADDITION, the applicant must submit photocopies of any complaints, hearings, settlements or judgments together with copies of patient’s hospital and/or office records to the AMB.***

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claim, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale & Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

**CONFIDENTIAL  
PHYSICIAN HEALTH PROGRAM**

1. Within the last five years, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Are you now being treated or have you in the last 5 years been treated for a drug or alcohol addiction or participated in a rehabilitation program? <b>*If in a confidential program in another state see explanation below.</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice? <b>See below for definition of ability to practice medicine.</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

***In the event you answer YES to any of the above questions, you must file with the application a detailed written narrative statement concerning the above matter(s), including the name of 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 the past 5 years pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with a compliance reports from the state monitoring programs***

**FAILURE TO PROPERLY ANSWER THESE QUESTIONS CAN RESULT IN BOARD DISCIPLINARY ACTION, INCLUDING REVOCATION OR DENIAL OF A LICENSE.**

**Ability to practice medicine is to be construed to include all of the following:**

- 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;**
- 2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and**
- 3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.**

**(THIS SECTION INTENTIONALLY LEFT BLANK)**

The applicant \_\_\_\_\_

**(PRINT OR TYPE YOUR NAME)**

being first duly sworn upon his oath deposes and says: that I am the person herein named subscribing to this application; that 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; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Arizona Medical Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Arizona Medical Board or its successors to release to the organizations, individuals or groups listed above any information which is material to the application or any subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

- I am a U.S. Citizen or U.S. National (If this box is checked please submit with your application a copy of one of the listed approved supporting documents listed in the “Arizona Statement of Citizenship and Alien Status for State Public Benefits” i.e. Birth Certificate, U.S. Passport, etc.)
- I am NOT a U. S. Citizen or U.S. National (If this box is checked you must download, complete and submit with your application “Arizona Statement of Citizenship and Alien Status for State Public Benefits” form along with a copy of one of the listed approved supporting documents i.e. Alien Registration Card, Visa, etc.)

**Signature of Applicant** \_\_\_\_\_, **M.D.**    **Date** \_\_\_\_\_

If you would like to designate/authorize ONE other individual beside yourself to check the status of your application with the AMB, please complete the following information:

Individual Name \_\_\_\_\_ Phone # \_\_\_\_\_ E-Mail: \_\_\_\_\_

**\* ARIZONA LAW REQUIRES AN APPLICANT WHO HAS BEEN CHARGED WITH A FELONY OR A MISDEMEANOR INVOLVING CONDUCT THAT MAY AFFECT PATIENT SAFETY AFTER SUBMITTING THE APPLICION TO NOTIFY THE AMB WITHIN 10 DAYS AFTER THE CHARGE IS FILED. ARIZONA REVISED STATUTE (A.R.S.) §32-3208 (SEE WEBSITE UNDER *Physician Center – Reportable Misdemeanors* FOR LIST OF REPORTABLE MISDEMEANORS – ALL FELONIES ARE REPORTABLE.)**



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**MALPRACTICE ADDENDUM**

(Complete this form if you answered YES to question #23 on the application)

The applicant must complete this form for each malpractice settlement or judgment in the last ten (10) years. If more than one case, please make copies of this form and return with required documents. Please report only the settlement of a civil action.

Applicant Name \_\_\_\_\_, M.D.

1. On a separate sheet of paper type your full name and provide a detailed clinical narrative regarding each malpractice case(s). Include name of patient, age, sex, date of occurrence and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description that includes all of the facts requested above. **NOTE: HIPAA regulations do not prevent you from responding and providing the requested information.**
2. Indicate your position in case, i.e., intern, resident, primary doctor, etc.  
\_\_\_\_\_
3. Case was filed against: Individual doctor  Group  Hospital
4. What was the amount and date of the judgment or settlement? \_\_\_\_\_  
Amount Date
5. Amount of judgment or settlement attributed to you \_\_\_\_\_
6. Has this case been investigated or reviewed by any State Medical Board?  Yes  No  
If answer is "Yes", request letter of resolution from State Medical Board be sent directly to us. You do not need to attach the documents listed below if the case has been investigated or reviewed by any State Medical Board.

You are required to attach the following for each case:

- Copy of plaintiff's complaint
  - Copy of Judgment or Settlement Agreement
  - Copy of complete set of medical records including x-rays or diagnostic films
- \* X-rays and diagnostic films must be included. Your application cannot be processed without them.

I certify that the information which I have provided is correct to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Your application is not administratively complete until all documents are received.



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**Home Address, Telephone Number, Social  
Security Number and Date of Birth**  
(Confidential Information, see below)

**Please Read Carefully**

**RETURN WITH APPLICATION**

Arizona Revised Statute (A.R.S.) §32-1435(B) requires the licensee to provide the Arizona Medical Board with a current address and telephone number. Additionally, A.R.S. § 32-3801 mandates that the Arizona Medical Board not provide access to a physician's home address and telephone number unless these are the only address and telephone number of record. Please ***do not*** indicate your home address and telephone number on any other application forms for licensure.

Please type or legibly print the following information:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Home Street Address

\_\_\_\_\_  
City, State, Zip or Postal Code, Country

\_\_\_\_\_  
Home phone number (including area code)

\_\_\_\_\_  
Office Phone Number

\_\_\_\_\_  
Mobile Phone Number

\_\_\_\_\_  
Office Fax

\_\_\_\_\_  
E-mail

Home address and telephone phone number will remain confidential  
***unless it is the only address and telephone number of record.***

**Please send all correspondence to \_\_\_\_\_ Home \_\_\_\_\_ Office**

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth (Month, Day and Year)

\_\_\_\_\_  
City and State or Country of Birth

**SOCIAL SECURITY NUMBER, DATE OF BIRTH AND PLACE OF BIRTH ARE CONFIDENTIAL  
INFORMATION – NOT FOR PUBLIC DISCLOSURE**

**TO BE COMPLETED BY THE MEDICAL SCHOOL AND/OR THE TEACHING HOSPITAL'S ACCREDITED GRADUATE MEDICAL EDUCATION PROGRAM IN THE STATE OF ARIZONA**

This is to certify that \_\_\_\_\_, M.D.

will be engaged in a teaching capacity in and for the \_\_\_\_\_

for a period beginning \_\_\_\_\_ and ending on \_\_\_\_\_.

**(ONE-YEAR INCREMENTS – Month/Day/Year)**

Signature of Dean/Director \_\_\_\_\_, M.D. Date \_\_\_\_\_

Typed/Printed Name of Dean/Director \_\_\_\_\_, M.D.

School/Teaching Hospital Name \_\_\_\_\_

School/Teaching Hospital Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Facsimile Number \_\_\_\_\_

(SCHOOL/HOSPITAL SEAL)  
(If no seal, please indicate)

Notice of re-application of a teaching license must be submitted one (1) month prior to expiration date. The medical school or affiliated accredited training program hospital must submit an updated medical school certification form, the applicable fee and documented proof that the applicant's license to practice medicine in another state or Territory of these United States, the District of Columbia, Canadian province or a foreign country remains current and in good standing. The medical school and the applicant are responsible for submitting this documentation.

**FOR BOARD USE ONLY**

Application Approved \_\_\_\_\_ 20 \_\_\_\_ By \_\_\_\_\_

Teaching License No. \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Teaching License re-issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_



ARIZONA MEDICAL BOARD

PAYMENT CARD AUTHORIZATION  
TEACHING LICENSE

Payment for: \_\_\_\_\_ M.D.

**TEACHING LICENSE FEE \$250.00**

\* \$8.00 Convenience fee (credit card processing fee) added to all credit card transactions.

Type of Card:  Visa  MasterCard  American Express

Card #:  -  -  -

Expiration Date:  -  (MM-YY)

Name as Shown on Payment Card: \_\_\_\_\_

**Billing Address:**

(Required)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number of Cardholder: \_\_\_\_\_

(Required)

**Mailing Address:** (If different from billing address)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete and return this form with your application and all necessary documents for licensure if paying by credit card.

This form and the application may be faxed to: 480-551-2704

If faxing this form, please do not mail the original as you may be charged twice.

OR

You may mail the form and all necessary documents to: Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258