**Arizona Medical Board**

9545 E. Doubletree Ranch Road Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 Toll Free: 877-255-2212 Fax: 480-551-2707
Website: www.azmd.gov

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# Attention Applicants

Thank you for your interest in obtaining a license to practice medicine in Arizona. We are excited to have the opportunity to work with you and help guide you through the application process.

Our mission is to protect public safety through the judicious licensing, regulation and education of all allopathic physicians. A license to practice medicine in Arizona is a privilege, not a right. Please do not assume that licensure is a mere formality or that granting of a license is automatic. Please give your application the time and attention needed to accurately answer all questions. It is the applicant's responsibility to ensure that the information disclosed on the application is correct.

Once your completed application and fee are received by the Board, your application will be reviewed to determine if all items needed to meet Arizona's Revised Statutes and Rules for licensure have been submitted. Please understand that some of the documentation required for licensure must come from the primary source (third party). This can add time to the licensing process. It is the applicant's responsibility to request the documentation from the primary source to be sent directly to the Board. A checklist is provided with this application packet for your convenience.

Some applications evidencing a history of disciplinary action require in-depth investigation and may require additional time and your cooperation. It may become necessary for an applicant to come to the Board's office in Scottsdale for an interview as part of the application process. Additionally, if an investigation is required, your application must go before the full Board for consideration of your application.

We will make every effort to complete the application process as quickly as possible. If you have any questions, please do not hesitate to call or email the Board's office. Our staff is happy to assist you in any way we can.

Again, thank you for your interest in an Arizona medical license.

## FOR YOUR INFORMATION

***Documents submitted prior to your license application:***

*To ensure your application is processed in a timely manner, you may request your documents to be sent directly from the entity to the Board prior to the submission of your application. Documents received prior to the submission of your application will be kept on file with the Board for 365 days.*

***Application Review Process:***

*Board staff will review your application and determine if all items needed to complete your application have been submitted to the Board. If it is determined that your application has deficient items, Board staff will send you a notice with a list of the items still needed to meet requirements. Please allow 15 days for your application to be reviewed by Board staff before calling and requesting a status update. Correspondence will be sent to your email address provided on the application.*

*Once all information needed to meet the requirements for licensure have been submitted to the Board, your application will undergo a final review by Board staff to ensure all requirements set forth in the Arizona Revised Statutes and Rules have been met.*

***Please note:*** *It is the applicant's responsibility to report to the Board any changes that may have occurred during the application process. Failure to report any adverse actions to the Board during the licensure process may result in denial or revocation of your license.*

*To review the Arizona Revised Statutes and Rules to ensure that you meet the requirements for licensure, please go to www.azmd.gov.*

32-3208. Criminal charges; mandatory reporting requirements; civil penalty

A. A health professional who has been charged with a misdemeanor involving conduct that may affect patient safety or a felony after receiving or renewing a license or certificate must notify the health professional's regulatory board in writing within ten working days after the charge is filed.

B. An applicant for licensure or certification as a health professional who has been charged with a misdemeanor involving conduct that may affect patient safety or a felony **after submitting the application** must notify the regulatory board in writing within ten working days after the charge is filed.

C. On receipt of this information the regulatory board may conduct an investigation.

D. A health professional who does not comply with the notification requirements of this section commits an act of unprofessional conduct. The health professional's regulatory board may impose a civil penalty of not more than one thousand dollars in addition to other disciplinary action it takes.

E. The regulatory board may deny the application of an applicant who does not comply with the notification requirements of this section.

F. On request a health profession regulatory board shall provide an applicant or health professional with a list of misdemeanors that the applicant or health professional must report.

# *Checklist for an Initial or Endorsement License Application*

**Please do not submit this form with your application. Keep it for your records.**

| APPLICATION FEE | |
|---|---|
| ☐ Application Fee | The application fee is $500 payable by check or credit card. The application fee must be submitted with the application and is non-refundable |
| ☐ License Fee | Once your license application is approved, you will be required to pay a prorated licensure issuance fee up to $500. This fee is prorated based on your birth year and month. |
| **LICENSE APPLICATION** | |
| ☐ Completed Application | Provide a complete application, pages 1 - 10. You must complete all questions. Make sure page 7 is notarized. If you fail to complete a question, your application will be considered deficient and the processing of your application will be delayed. |
| **FINGERPRINTS** | |
| ☐ Fingerprint Card | Applicants are required to undergo a criminal background check according to A.R.S. § 32-1422(12). A fingerprint packet will be sent to the applicant's mailing address provided on the application. The fingerprint card is specific and pre-printed for the Board; therefore, the applicant must use the fingerprint card provided by the Board. Fingerprinting can be done at a local police department, sheriff's office, or an entity that provides fingerprinting services. Please contact the entity that provides the fingerprint service and confirm availability and payment requirements**.** The applicant is required to return the fingerprint card along with a check, money order or credit card for $50.00 made out to "Arizona Medical Board" together in the return envelope. The fingerprint technician is required to fill out and date the identity verification form, place it with the fingerprint card and check or money order, seal and sign the envelope flap before returning the fingerprint card to the applicant. If the applicant forgets to place the check or money order with the fingerprint card, do not reopen the sealed envelope. The applicant can include the check or money order in a separate envelope attached to the return fingerprint card envelope. Failure to return the sealed envelope with the fingerprint card, identity verification form, check or money order and the fingerprint technician's signature across the envelope flap will delay the processing of your application. Do not send the fingerprint card prior to the submission of your application. |
| **EVIDENCE OF LEGAL STATUS** | |
| ☐ A notarized Copy of Your Birth Certificate or Passport | Applicants must provide a notarized photocopy of a Birth Certificate or Passport. A Notarized Certificate of Identification form is provided with the application packet for your convenience. |
| ☐ Proof of Immigration status | A list of the documents that are required to be submitted to the Board is included with the application. |
| ☐ Government Issued Photo ID (Copy) | A copy of a government issued photo ID is required if the proof of legal status does not include a photo. Example: driver license or state I.D. |
| ☐ Evidence of legal name change | Applicant must provide evidence of legal name change, if applicable. Example: Marriage Certificate, court documents showing legal name change. |

| MEDICAL SCHOOL | |
|---|---|
| ☐ Medical College Certification | One of the following must be submitted directly from your medical school to the Board:<br>- An official copy of your medical school transcripts<br>- A copy of your Diploma<br>- A letter with an official letterhead that confirms successful completion |
| ☐ Foreign graduates only:<br>ECFMG Certification, 5th Pathway or 36 months Clinical Instructor Certification | ECFMG certification must be sent directly to the Board, available online at www.ecfmg.org.<br>A clinical instructor must complete 36 months as a full-time employed/compensated assistant professor or higher. |
| **POST GRADUATE TRAINING** | |
| ☐ Post Graduate Training Certification | The post graduate training form is included with the application. This form must be filled out and submitted **directly to the Board from** the post graduate training program. It is the applicant's responsibility to provide this form to the training program.<br><br>The Board must receive verification from your training program for the following:<br><br>U.S. or Canadian Graduates:<br>12 months of ACGME and/or RCPSC approved post graduate training<br><br>Foreign Graduates:<br>36 months of ACGME approved post graduate training<br><br>**Please note:** Only verified postgraduate training from the primary source will be added to your website profile upon approval of your license. |
| **EXAMINATION** | |
| ☐ Examination Scores | Official examination scores must be sent directly to the Board. Examination scores may be requested from the following websites:<br><br>USMLE Exam Scores:<br>Available online at www.usmle.org<br><br>NBME Exam Scores:<br>Available online at www.nbme.org)<br><br>FLEX Exam Scores:<br>Available online at www.fsmb.org<br><br>LMCC Exam Scores:<br>Available online at www.mcc.ca<br><br>State Written and SPEX Exam Scores :<br>To be requested from the specific state |
| **VERIFICATION OF OTHER STATE LICENSE(S)** | |
| ☐ State/Province Licensure Verification | License verification is required to be sent directly to the Board from **each** state or province in which you hold or have held a license. Verification(s) of training permits or registrations are **not** required. If you obtain a license during the licensure process, you must request the verification to be sent directly to the Board. *The Board accepts verifications from Veridoc. |

| HOSPITAL AFFILIATIONS/MEDICAL EMPLOYMENT | |
|---|---|
| ☐ Hospital Affiliations/ Medical Employment Verifications | You must request verification(s) from the following;<br><br>1. All hospital affiliations during the five years before the date of the application on the hospital's official letterhead or electronic equivalent. If the applicant was affiliated with a hospital through a medical group or organization, the verification shall be supplied by the employer.<br><br>2. Verification(s) of all medical employment during the five years before the date of the application to be sent directly to the Board on official letterhead by the entity. |

| MALPRACTICE DOCUMENTS | |
|---|---|
| ☐ Pending or settled malpractice documents | The following **must** be provided if you have a pending malpractice claim or malpractice settlement:<br><br>• Detailed narrative/explanation (provided by the applicant)<br>• Copy of the complaint<br>• Agreed terms of settlement or the judgment<br><br>***Please note** - All pending malpractice claims and settlements must go before the full board for review. If a full review is recommended, you may be requested to provide the medical records for the case. |

| QUESTIONNAIRE AFFIRMATIVE RESPONSES | |
|---|---|
| ☐ Narrative and Supporting Documents | If you answer "yes" to a question on the questionnaire page, please provide the following:<br><br>• A narrative/explanation of the circumstances that led to the issue disclosed.<br>• Documents to support your narrative. Example: Court documents, Board Orders, etc.<br><br>*If documents are not provided, this **will** delay the application process.<br><br>**Please note:** It is the applicant's responsibility to report to the Board any changes that may have occurred during the application process. Failure to report any adverse actions to the Board during the licensure process may result in denial or revocation of your license. |

| Controlled Substances Prescription Monitoring Program Registration | |
|---|---|
| ☐ CSPMP Registration Application | A CSPMP registration and questionnaire is included with this packet. You **must** complete and submit the CSPMP questionnaire. If you intend to possess a DEA permit or you currently possess a DEA permit , you **must** complete and submit the CSPMP registration application. Failure to submit this information to the Board will delay the processing of your application. |

| Information requested to be sent directly to the Board can be sent to the following: | |
|---|---|
| Email: licensingreport@azmd.gov | Arizona Medical Board<br>9545 E. Doubletree Ranch Road<br>Scottsdale, AZ 85258 |

| FCVS PACKETS | | |
|---|---|---|
| The Board will accept an FCVS packet. The following verifications provided in the FCVS packet may be accepted by the Board: | · Medical School Certification<br>· Post Graduate Training Certification<br>· ABMS Certification | · ECFMG Certification<br>· Evidence of legal status documents<br>· Examination Scores |

# ARIZONA MEDICAL BOARD
# MD INITIAL AND ENDORSEMENT LICENSE APPLICATION

9545 E. Doubletree Ranch Rd., Scottsdale, AZ 85258
www.azmd.gov; Email: licensingreport@azmd.gov

Revised 6/9/2016

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

## Personal Information

Attach a headshot photograph of passport quality. The photograph must not be taken more than 60 days before the date of the application.

Please, no staples

**1. First Name:**

**Middle Name:**

**Last Name:**

Other Names Used:

**2. Social Security Number:**

**3. Date of Birth:** **State of Birth:**

**City of Birth:** **Country of Birth:**

***Social Security Number, Date of Birth and Place of Birth are Confidential Information - Not for Public Disclosure***

## Address Information

**Practice Address:** This is the practice/principal place of your business. The address and phone number provided will appear in the Medical Directory and on the Board's website. **Every physician must have an address available to the public**. If only one address is provided, even if it is your home address, it will be available to the public upon request. If you want your home address to be listed as your practice address on the Board's website, include the address in the practice address field.

**4. Practice/Training Name:**

**Address:** **City:** **State:** **Zip:**

**Phone:** **Fax:** ***Practice address not required for licensure**

**Home Address:** You are **required** to provide a home address, telephone number and email address. Your home address and telephone number will not be released to the public *unless* you fail to provide an office address. Your email address will not be released to the public.

**5. Home Address:** **City:** **State:** **Zip:**

**Phone:** **Mobile:**

**Primary Email Address:**

**Mailing Address:** If no address is provided, all Board correspondence will be sent to your practice address. **Please note** - Your fingerprint packet will be sent to your mailing address.

**6. Mailing Address:** **City:** **State:** **Zip:**

☐ Same as Practice Address ☐ Same as Home Address

**In addition to your primary e-mail address provided on page one of this application, please indicate if you would like to designate/authorize an individual or prospective employer, beside yourself, to receive status updates on your application.**

**Please note: If a substantive review/investigation is required during the application process, the applicant will be required to provide additional authorization, in writing, for the third party to receive status updates concerning the substantive review.**

Name _____ Phone# _____ E-mail _____

Name _____ Phone# _____ E-mail _____

☐ **Check this box if you are using Federation Credentials Verification Service (FCVS)**

Please Note: The Arizona Medical Board accepts FCVS documents that are received by the Board directly from the Federation of State Medical Boards (FSMB) as verification. Contact the Federation at http://www.fsmb.org if you need more information regarding this service.

☐ **Once granted licensure in Arizona, I would like to review cases for the Board. I have 5 years + experience (excludes PGT).**

If you are interested please go to www.azmd.gov for more details. Please list your Specialty, Sub Specialty, or type of procedures that you are qualified to review.

Specialty/Sub Specialty/procedures: _____

## 7. Other State Medical License(s)

Please list all states, provinces or U.S. territories in which you have applied for or have been granted a license or registration to practice medicine, including license number, date issued and current status of the license. If more than 10, attach a separate listing. If a license is pending or was not issued, so state. Please do not list registrations or post graduate training license(s). **If none, please indicate "Not Applicable".**

| State Board: | License No.: | Date Issued: | License Status: |
|---|---|---|---|
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**First Name:** _____ **Last Name:** _____

## 8. Medical Education

**Medical School Name:**

**Medical School Location:** **Graduation Date:**

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

ECFMG No.: Certificate Date:

☐ *I am able to read, write, speak, understand and be understood in the English language.*

## 9. Post Graduate Training

List chronologically, all internship, residency and fellowship training in the U.S. or Canada (completed or not), or assistant professorship (or higher, if needed to meet requirements) at any program attended, showing institution, address, type of program, specialty and dates. Attach a separate listing, if needed.

a. Institution: City: State:

Dates of Attendance: From: To: Type of Program:

Specialty:

b. Institution: City: State:

Dates of Attendance: From: To: Type of Program:

Specialty:

c. Institution: City: State:

Dates of Attendance: From: To: Type of Program:

Specialty:

d. Institution: City: State:

Dates of Attendance: From: To: Type of Program:

Specialty:

e. Institution: City: State:

Dates of Attendance: From: To: Type of Program:

Specialty:

**First Name:** **Last Name:**

## 10. Examinations

Please indicate all exams taken.

| | |
|---|---|
| ☐ United States Licensing Exam (USMLE) | ☐ National Board of Medical Boards Licensing Examination (NBME) |
| ☐ State Written Exam | ☐ Federation of State Medical Boards Licensing Examination (FLEX) |
| ☐ Licentiate of the Medical Council of Canada (LMCC) | ☐ Special Purpose Examination (SPEX) |

## 11. Area of Interest/ABMS Certification

Indicate your area of interest/specialty (present or future, can be updated if needed) and whether you are certified by the American Board of Medical Specialties (ABMS). **This must be completed.**

| Area of Interest | Practicing? | ABMS Certified? | Expiration Date (Or indicate if lifetime certificate) |
|---|---|---|---|
| | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| | ☐ Yes ☐ No | ☐ Yes ☐ No | |

## 12. Citizenship Attestation

**Proof of Citizenship:** Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States, Pursuant to A.R.S. § 41-1080 and A.A.C. R4-16-201(C)(1) require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona.

| | |
|---|---|
| ☐ **I am a U.S. Citizen or U.S. National.** | If this box is checked, please submit documentation as stated on the Statement of Citizenship form (Also review the application checklist). |
| ☐ **I am NOT a U.S. Citizen or U.S. National.** | If this box is checked, please submit documentation as stated on the Statement of Citizenship form (Also review the application checklist). |

## 13. Training Unit Attestation

Initial Applications - A.R.S. §32-1422(A)(10): Complete a training unit as prescribed by the board relating to the requirements of this chapter and board rules. The applicant shall submit proof with the application form of having completed the training unit.

***I am aware that I am responsible for knowing and adhering to the laws governing the practice of medicine in Arizona. I declare under penalty of perjury that I have read and completed all four pages of the training unit provided with this application and available on the Board's website.***

**Revised 10/20/15**

**Full Name (print):** _____ **Signature:** _____

**Date:** _____

## 14. Questionnaire

1. Have you had an application for medical licensure denied or rejected by another state or province licensing board? ☐ Yes ☐ No
2. Have you had any disciplinary or rehabilitative action taken against you by another licensing board, including other health professions? ☐ Yes ☐ No
3. Have you had any disciplinary actions, restrictions or limitations taken against you while participating in any type of training program or by any health care provider? ☐ Yes ☐ No
4. Have you been found in violation of a statute, rule, or regulation of any domestic or foreign governmental agency? ☐ Yes ☐ No
5. Are you currently under investigation by any medical board or peer review body? ☐ Yes ☐ No
6. Have you ever had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation during an investigation, or entered into a consent agreement or stipulation? ☐ Yes ☐ No
7. Have you had hospital privileges revoked, denied, suspended, or restricted? ☐ Yes ☐ No
8. Have you been named as a defendant in a malpractice matter currently pending or that resulted in a settlement or judgment against you? If so, provide a copy of the complaint and either the agreed terms of settlement or the judgment and a statement specifying the nature of the occurrence resulting in the medical malpractice action. ☐ Yes ☐ No
9. Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by an agency of the federal or state government? ☐ Yes ☐ No
10. Have you had the authority to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency as a result of disciplinary or other adverse action? ☐ Yes ☐ No
11. Have you been found guilty or entered into a plea of no contest to a felony, or a misdemeanor involving moral turpitude in any state? ☐ Yes ☐ No

## 15. Confidential Questions

1. Have you received treatment within the last five years for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narcotic or a physical, mental, emotional, or nervous disorder or condition that currently affects your ability to exercise the judgment and skills of a medical professional? If so, provide the following: ☐ Yes ☐ No

A.) A detailed description of the use, disorder, or condition; and
B.) An explanation of whether the use, disorder, or condition is reduced or ameliorated because you receive ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating.
C.) A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.

The purpose of the confidential question is to allow the Board to determine the applicant's current fitness to practice medicine. The mere fact of treatment, monitoring or participation in a support group is not, in itself, a basis of which admission is denied; the Board routinely licenses individuals who demonstrate personal responsibility and maturity in dealing with fitness issues. The Board encourages those applicants who may benefit from assistance to seek it. The Board may limit or deny licensure to applicants whose ability to function is impaired in a manner relevant to the practice of medicine at the time the licensing decision is made or to applicants who demonstrate a lack of candor by their responses. This is consistent with the public purpose that underlies the licensing responsibilities assigned to the Arizona Medical Board and to the applicants seeking licensure.

**NOTE: In the event that the response to any of the questions is "Yes", you must file an explanation and submit photocopies of any corresponding documents. Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.**

Moral Turpitude includes but is not limited to: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Embezzlement, Fabricating and Presenting False Public Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and 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, Theft and Soliciting Prostitution.

**First Name:** _____ **Last Name:** _____

## 16. Hospital Affiliations/Medical Employment Verifications

**Please answer all questions and list all hospital affiliations and medical employment within the past five (5) years, including moonlighting and courtesy staff affiliations.** ***Do not include postgraduate training or self-employment***. List all physician placement groups related to hospital employment, emergency medical groups, radiology groups, etc. **This form must be completed.**

1. I have been self-employed for the past 5 years. (If yes do not list your self-employment below) ☐ Yes ☐ No
2. My only medical employment for the past 5 years has been postgraduate training. (If yes do not list your postgraduate training below.) ☐ Yes ☐ No
3. I have had no medical employment for the past 5 years. ☐ Yes ☐ No
4. I have not held hospital affiliations within the past 5 years or I am currently in postgraduate training. (If yes do not list your postgraduate training below.) ☐ Yes ☐ No

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**a. Name:** _____ From: _____ To: _____

Address: _____ City: _____ State: ____ Zip: _____

Position Held: _____ ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

**b. Name:** _____ From: _____ To: _____

Address: _____ City: _____ State: ____ Zip: _____

Position Held: _____ ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

**c. Name:** _____ From: _____ To: _____

Address: _____ City: _____ State: ____ Zip: _____

Position Held: _____ ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

**d. Name:** _____ From: _____ To: _____

Address: _____ City: _____ State: ____ Zip: _____

Position Held: _____ ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

**e. Name:** _____ From: _____ To: _____

Address: _____ City: _____ State: ____ Zip: _____

Position Held: _____ ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

**First Name:** _____ **Last Name:** _____

## 17. Attestation

I attest that all of the information contained in the application and accompanying evidence or other credentials submitted are true. I attest the credentials submitted with the application were procured without fraud or misrepresentation or any mistake of which I am aware, and that I am the lawful holder of the credentials. I authorize the release of any information from any source requested by the Board necessary for initial and continued licensure in this state.

Signature of Applicant: Date:

Notarization

Subscribed and sworn in front of me by_____, personally appearing on this date_____.

_____
Notary Public's Signature

(Personalized Seal)

**First Name:** **Last Name:**

**18.**

# ARIZONA STATEMENT OF CITIZENSHIP OR ALIEN STATUS FOR STATE PUBLIC BENEFITS

Professional License and Commercial License
Arizona Medical Board

M.D. License Applicants

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/CERTIFICATION (Check one)

- ☐ MD Initial or Endorsement Application
- ☐ Teaching License
- ☐ Education Teaching Permit
- ☐ Pro bono registration
- ☐ Post Graduate Training Permit
- ☐ 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 of Birth:** _____ **State (or equivalent):** _____ **Country or Territory:** _____

If you answered **Yes**, 1) Attach a photocopy of a document from the attached list, section A. Documents from List B also apply to U.S. Citizens, but submission of a List B document does not negate the requirement to submit a copy of an item from List A.

**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 copy of a document from the attached list, section A. Additionally, submit an item from the attached list section C or other document as evidence of your 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 (e.g. marriage certificate) if the name on your evidence is not the same as your current legal name.

Citizens must submit one of the documents in list A. If applicable, citizens shall also submit a document from list B, but it does not negate the requirement to submit an item from list A. A copy of a government issued photo ID is required if the proof of legal status does not include a photo.

Non-citizens must provide one item from both lists A and C.

**List A** (Applicable to both citizens and non-citizens)

1. A notarized copy of a birth certificate

Or

2. A notarized copy of a passport

**List B**

1. A United States certificate of naturalization.
2. A United States certificate of citizenship.
3. A tribal certificate of Indian blood.
4. A tribal or Bureau of Indian Affairs affidavit of birth.

**List C** (Applicable to non-citizens only)

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. This must be accompanied with a statement by the state issuing entity that the state verifies legal status prior to issuing the license.
3. A foreign passport with a United States Visa.
4. An I-94 form with a photograph.
5. A United States Citizenship and Immigration Services employment authorization document or refugee travel document.
6. Any other license that is issued by the federal government, any other state government, an agency of this state or political subdivision of this state that requires proof of citizenship or lawful alien status before issuing the license.

## 19. Controlled Substances Prescription Monitoring Program Registration

State law, specifically, Arizona Revised Statutes § 36-2606, requires every Arizona medical practitioner who possesses a Drug Enforcement Administration ("DEA") permit to also hold a Controlled Substances Prescription Monitoring Program ("CSPMP") registration issued by the Arizona State Board of Pharmacy ("Pharmacy Board"). The failure of a medical practitioner to obtain a CSPMP registration may result in disciplinary action by the practitioner's licensing board. See A.R.S. § 36-2607.

Arizona Revised Statutes § 32-3219, mandates the Arizona Medical Board ("Board") to notify the Pharmacy Board of newly-licensed physicians who intend to apply for a DEA permit and physicians who renew their licenses. The Board is also required to submit to the Pharmacy Board information to assist the Pharmacy Board in the registration of medical professionals for the CSPMP. To facilitate the Board's collection of this information please complete the enclosed form and submit it to the Board along with your license application/renewal application.

If you have any questions regarding the attached form, please contact Dean Wright at 602-771-2744.

**THIS FORM MUST BE RETURNED TO THE ARIZONA MEDICAL BOARD IN ORDER TO COMPLETE YOUR APPLICATION. YOU MUST ALSO SUBMIT THE ATTACHED APPLICATION FOR THE CSPMP REGISTRATION IF YOU INTEND TO APPLY FOR A DEA REGISTRATION OR IF YOU CURRENTLY HAVE A DEA PERMIT.**

| | |
|---|---|
| 1. Do you intend to apply for an Arizona DEA permit? | ☐ Yes ☐ No |
| 2. Do you currently have a DEA permit? | ☐ Yes ☐ No |

**First Name:** _____ **Last Name:** _____

# Arizona State Board of Pharmacy

## Application for REGISTRATION - Medical Practitioner and Access to the Arizona Controlled Substances Prescription Monitoring Program

FOR OFFICE USE ONLY

PRINT CLEARLY USING CAPITAL LETTERS

**License Type** ☐ MD ☐ MD(H) ☐ DO ☐ DO(H) ☐ DDS ☐ DMD ☐ DPM ☐ PA ☐ NP ☐ ND ☐ OD

**State Licence Number**

**Expiration Date** / /

***DEA Number** -

**MEDICAL RESIDENTS - Add the suffix assigned to the Facility DEA# above**

**Expiration Date of DEA** / /

**MEDICAL RESIDENTS:**

**Assigned Resident License #**

**Expiration Date of Resident License #** / /

**NPI Number**

**SECURITY QUESTIONS:**

**Mother's Maiden Name**

**Your birth City:**

**1. DEMOGRAPHICS**

Legal First Name

Middle Name

Legal Last Name

Last 4 Digits of SSN

Date of Birth / /

**2. PRACTICE ADDRESS**

Street Address Line 1

Street Address Line 2

City

State

Zip Code

County

Work Phone - -

Fax - -

**3. Complete If Mailing Address is NOT the same as PRACTICE ADDRESS**

Street Address Line 1

Street Address Line 2

City

State

Zip Code

County

**4. Medical Practitioner's - Work or Personal E-mail Address**

***If a Medical Practitioner has multiple DEA numbers, you MUST complete one form for each DEA number**

**Directions:**
Please read the case studies and general questions along with the correct responses to each of the questions posed. This training module is designed to increase your awareness of the statutes and rules that govern the practice of medicine in Arizona. When you have read through the material, please sign the attestation indicating you have done so and that you are aware that the Medical Practice Act contains the statutory obligations you must meet when you practice medicine in Arizona. Please be advised that you may access the Medical Practice Act and the corresponding rules on the Board's website: www.azmd.gov

# Medical Practice Act Training & Questionnaire

**CASE STUDIES (Multiple Choice)**

This section illustrates common violations of the MPA by using case scenarios. Each scenario is followed by a multiple-choice question and the answer.

### *1. Sexual Conduct*

*Scenario:* You and a patient develop mutual feelings for each other during the course of treatment. You begin dating the patient and mutually agree to begin a sexual relationship. Should you continue to medically treat the patient?

A. Yes. The treatment began before a sexual relationship was developed. Therefore, it is appropriate to continue treating the patient as you were before.
B. Yes. You can maintain a boundary between your personal feelings for the patient and your professional practice.
C. No. The physician-patient relationship must be terminated six months before engaging in sexual conduct.
D. No. A physician should never establish a sexual relationship with a current or former patient.

*Answer:* C. No. The physician-patient relationship must be terminated six months before engaging in sexual conduct.

A.R.S. 32-1401(27)(z) states that it is unprofessional conduct to engage in sexual conduct with a current patient or with a former patient within six months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating or engagement relationship with the licensee.

### *2. Controlled Substances*

*Scenario:* You are experiencing back pain after a weekend spent moving into a new home. You know the appropriate dose of Oxycodone to relieve your pain. Instead of requesting an appointment with your primary care physician you call in a prescription to the pharmacy for yourself. Are your actions appropriate?

A. No. Regardless of how seemingly obvious the cause of the pain and type of controlled substance needed, it is never appropriate for a physician to self-prescribe a controlled substance.
B. No. There are alternative over the counter drugs that can provide the same effect.
C. Yes. You had the same back pain in the past and you were previously prescribed the same medication.
D. Yes. You are a licensed physician. You know exactly what medications you need to feel better.

*Answer:* A. No. Regardless of how seemingly obvious the illness and type of controlled substance needed, it is never appropriate for a physician to self-prescribe a controlled substance.

A.R.S. 32-1401(27)(g) states that it is unprofessional conduct to use controlled substances except if prescribed by another physician for use during a prescribed course of treatment.

### *3. Professional Connection*

*Scenario:* Your friend "Bob" wants to open a laser clinic and perform varicose vein removal. Bob is not a licensed doctor in Arizona, but he holds a medical license in New Mexico. You are confident that Bob has the education and training to safely perform varicose vein removal, even though it is considered to be the practice of medicine in Arizona. You decide to help Bob out and let him operate his laser clinic under your name. Is this appropriate?

A. Yes. Even though Bob is not licensed in Arizona, he is a doctor and you know he will do a good job.
B. Yes. The clinic operates under your name and you know Bob will call you with any problems.
C. No. Varicose vein removal is considered to be the practice of medicine and Bob is not licensed to practice medicine in Arizona.
D. No. The state where Bob is licensed may have different regulations for operating a laser clinic than Arizona and you can't be sure if Bob's clinic will meet Arizona regulations.

*Answer:* C. No. Varicose vein removal is considered to be the practice of medicine and Bob is not licensed to perform medicine in Arizona.

A.R.S. 32-1401(27)(cc) states that it is unprofessional conduct to maintain a professional connection with or lend one's name to enhance or continue the activities of an illegal practitioner of medicine.

### *4. False or Fraudulent Statements*

*Scenario:* You are applying for privileges at a hospital and one of the questions asked of you is whether your license has ever been revoked or suspended. Knowing that the hospital will likely deny you privileges if you answer affirmatively, you opt to knowingly withhold the fact that your license was previously suspended over 15 years ago. Are your actions justified?

A. Yes. Because your suspension was so long ago, it is likely the hospital will never find out about it.
B. Yes. Ever since you got your license back, you have been a model physician and you have obeyed all laws.
C. No. The hospital will eventually find out and report you to the Board, resulting in more trouble.
D. No. It is never okay to make a false statement when applying for hospital privileges.

*Answer:* D. No. It is never okay to make a false statement when applying for hospital privileges.

A.R.S. 32-1401(27)(t) states that it is unprofessional conduct to knowingly make any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution.

### *5. Financial Interest*

*Scenario:* You are a pain specialist and many of the patients you see benefit from a combination of pain medication and other forms of therapy, such as physical therapy. In addition to your pain clinic, you are also part owner of an outpatient physical therapy clinic. If you prescribe physical therapy at the clinic where you are part owner, should you inform the patients that you have a direct financial interest in the clinic?

A. No. Your patients will receive good care at the physical therapy clinic and do not need to know.
B. No. The amount of money you receive from your ownership interest in the clinic is not enough to require you to inform your patients.
C. Yes. You should inform patients of your financial interest and let them know they can receive therapy elsewhere.
D. Yes. You should inform patients of your financial interest, but stress that they will receive the best therapy at your clinic.

*Answer:* C. Yes. You should inform patients of your financial interest and let them know they can receive therapy elsewhere.

A.R.S. 32-1401(27)(ff) states that it is unprofessional conduct to knowingly fail to disclose to a patient on a form that is prescribed by the board and that is dated and signed by the patient or guardian acknowledging that the patient or guardian has read and understands that the doctor has a direct financial interest in a separate diagnostic or treatment agency or in non-routine goods or services that the patient is being prescribed and if the prescribed treatment, goods or services are available on a competitive basis. This subdivision does not apply to a referral by one doctor of medicine to another doctor of medicine within a group of doctors of medicine practicing together. A "Notice To Patients" form can be downloaded off the Board's website.

## *6.* GENERAL QUESTIONS (True or False)

1. It is acceptable practice for me to prescribe controlled substances to my spouse and family.

   *(False: A.R.S. 32-1401(27)(h) states that it is unprofessional conduct to prescribe controlled substances to members of the physician's immediate family.)*

2. If a patient requests her medical records, I can provide a copy of the records, not the original.

   *(True: A.R.S. 12-2297 states that a health care provider shall retain the original or copies of the medical records.)*

3. If I don't provide the Arizona Medical Board with an office address, the Board can give the public my home address.

   *(True: A.R.S. 32-3801 states that a professional's residential address and residential telephone number or numbers maintained by the Board are not available to the public unless they are the only address and numbers of record.)*

4. I can ask my medical assistant to provide injections to my patients while I am out of the office.

   *(False: Medical assistants may only administer injections under the direct supervision of a physician, physician assistant or nurse practitioner. A.R.S. 32-1456. Direct supervision is defined in A.R.S. 32-1401 as being in the same room or office suite as the medical assistant.)*

5. I can earn one credit hour of continuing medical education by reading scientific journals and books.

   *(True: A credit hour may be earned for activities that provide an understanding of current developments, skills, procedures, or treatments related to the practice of allopathic medicine, including reading scientific journals and books. R4-16-101(B)(8).)*

6. If the Board issues me a non-disciplinary advisory letter, I can file a written response with the Board within thirty days of receiving the advisory letter.

   *(True: An advisory letter cannot be appealed, but physicians do have the right to file a written response. The written response is considered to be part of the public record and will be included with any public records requested on a physician.)*

7. I am required to report to the Board any information that appears to show that a doctor of medicine is or may be medically incompetent, is or may be guilty of unprofessional conduct, or is or may be physically unable safely to engage in the practice of medicine.

   *(True: A doctor of medicine is required to report to the Board any information that appears to show that a doctor of medicine is or may be medically incompetent, is or may be guilty of unprofessional conduct, or is or may be physically unable safely to engage in the practice of medicine. A.R.S. 32-1451(A).)*

8. I can charge a patient for medical records before I agree to send them to another physician.

   *(False: A health care provider may not charge for medical records provided to another health care provider for the purpose of providing continuing care to the patient. A.R.S. 12-2295.)*

9. If a patient asks for his medical records to be transferred to another provider, I am no longer responsible for retaining the records according to state retention laws.

   *(False: The law does not provide an exception to the medical record retention requirements. A.R.S. 12-2297.)*

10. The Arizona Medical Board can charge me $100 for failing to provide a current office and home address within 30 days of the date of the address change.

    *(True: The Arizona Medical Board may assess the costs incurred by the Board in locating a licensee and in addition a penalty of not to exceed one hundred dollars. A.R.S. 32-1435(B).)*

11. If I self report to the Board my substance abuse problem I may be eligible to participate confidentially in the Arizona Medical Board's treatment and rehabilitation program.

*(True: The Arizona Medical Board has a program for the treatment and rehabilitation of physicians who are impaired by alcohol or drug abuse. Physicians meeting the program requirements may participate confidentially. A.R.S. 32-1452.)*

12. I can prescribe to patients who fill out an on-line health questionnaire, even if I have never met them.

*(False: It is unprofessional conduct to prescribe, dispense or furnish a prescription or prescription-only device to a person without first conducting a physical examination or previously establishing a doctor-patient relationship. A.R.S. 32-1401(27)(ss).)*

13. If I don't receive a reminder from the Arizona Medical Board to renew my license on time, I am not responsible for a late fee or non-renewal.

*(False: It is your responsibility to ensure your license is renewed on time.)*

14. If my patient refuses to notify her spouse that she is HIV positive, I can report the name of her spouse to the Arizona Department of Health Services.

*(True: A.R.S. 32-1457 states that it is not an act of unprofessional conduct for a doctor to report to the department of health services the name of a patient's spouse or sex partner or a person with whom the patient has shared hypodermic needles or syringes if the doctor knows that the patient has contacted or tests positive for the human immunodeficiency virus and that the patient has not or will not notify these people and refer them to testing.)*

15. The Arizona Medical Board will only investigate a malpractice complaint if there was a settlement over one million dollars.

*(False: On receipt of a malpractice report and a copy of a malpractice complaint as provided in section 12-570, the health profession regulatory board shall initiate an investigation into the matter to determine if the licensee is in violation of the statutes or rules governing licensure. A.R.S. 32-3203.)*

# ARIZONA MEDICAL BOARD
# POSTGRADUATE TRAINING VERIFICATION FORM

**AUTHORIZATION:** The Arizona Medical Board requires all applicants for licensure to obtain verification of all postgraduate training programs attended. This form must be completed by the **Program Director**. This is authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board. Authorization may be sent via mail to 9545 E Doubletree Ranch Road, Scottsdale, AZ 85258, fax with cover letter: 480-551-2704 or by email to licensingreport@azmd.gov.

**First Name:** _____ **Middle Name:** _____ **Last Name:** _____

**Signature:** _____ **Date:** _____

**Applicant:** Do not fill in below this line.

---

**Important - Program Participation:** Report incomplete postgraduate years (PGY) separately from those that were successfully completed. If the postgraduate year is currently in progress, report the **expected completion date in the "To" field.** Report internships, residencies and fellowships separately.

**PG Year:** _____ **Department/Specialty:** _____

☐ Internship
☐ Residency
☐ Fellowship

From: _____ To: _____ (mm/dd/yy)

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

**PG Year:** _____ **Department/Specialty:** _____

☐ Internship
☐ Residency
☐ Fellowship

From: _____ To: _____ (mm/dd/yy)

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

**PG Year:** _____ **Department/Specialty:** _____

☐ Internship
☐ Residency
☐ Fellowship

From: _____ To: _____ (mm/dd/yy)

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

*Affix Training Program Seal Here*

**1. This program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Examination Education (ACGME), or the Royal College of Physicians and Surgeons of Canada:** ☐ **Yes** ☐ **No**

**2. Did this individual ever take a leave of absence or break from training or request a transfer?** ☐ **Yes** ☐ **No** (If yes, please attach an explanation)

**3. Was this individual disciplined and/or placed under investigation or probation?** ☐ **Yes** ☐ **No** (If yes, please attach an explanation)

**Institution Name:** _____ **Name:** _____

Address: _____ **Title:** _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

**Signature:** _____ **Date:** _____ (mm/dd/yy)

# CERTIFICATION OF IDENTIFICATION

Certification by Notary Public is Required

Applicant Full Legal Name:_____

Last First Middle

**<u>Notary</u> - Please complete the section below and attach a photocopy of the Birth Certificate or Passport.**

State of_____ County of_____

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this

(Day)_____, of (Month)_____, (Year)_____.

Notary Public Signature:_____

Commission Expiration Date* (Month)_____/(Day)_____/(Year)_____

***The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Applicant's Signature:_____

Notary Stamp Here

Please complete and mail or email the notarized Certificate of Identification form and a photocopy of the Birth Certificate or Passport presented to the Notary to:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Licensingreport@azmd.gov

# PAYMENT CARD AUTHORIZATION

First Name _____ Last Name _____

**MD APPLICATION PROCESSING FEE $500**
**MD FINGERPRINT FEE $50**
**TOTAL DUE: $550**

**Type of Card:** ☐ **Visa** ☐ **Mastercard** ☐ **Amex**

**Card Number:** _____ **Expiration Date:** _____

*(No dashes between numbers)*

**Name as Shown on Payment Card:** _____

**Billing Address of Cardholder:** _____ **City:** _____ **State:** ____ **Zip:** _____
**(Required)**

**Office Phone:** _____

**Mailing Address of Cardholder:** _____ **City:** _____ **State:** ____ **Zip:** _____
**(If different from billing address)**

**Cardholder Signature:** _____ **Date:** _____
**(Required)**

**Please complete and return this form *with your license application and all necessary documents* if paying by credit card. Or return the application and payment (this credit card form or check or money order) to the address listed below.**
**PLEASE NOTE: If faxing the credit card, do not mail as you may be charged twice.**

**Mail to:** **Arizona Medical Board**
**9545 East Doubletree Ranch Road**
**Scottsdale, AZ 85258**

Note: At the time the application is approved an additional prorated fee will be required up to $500. This is in addition to your $500 application fee and will cover your license through the next renewal period.