ARIZONA MEDICAL BOARD
CLINICAL INSTRUCTOR VERIFICATION FORM

AUTHORIZATION: The Arizona Medical Board requires all applicants for licensure to obtain verification of all hospitals where they have been employed as a clinical instructor. 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 or fax to 9545 E Doubletree Ranch Road, Scottsdale, AZ 85258 or (480) 551-2704.

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

Signature: _____ **Date:** _____

This is to certify that the applicant listed above was a full time (rank, i.e. assistant professor) _____

in the (type of program) _____ at (name of program) _____

Located in: City: _____ State: _____ in the field of: _____

From: _____ To: _____

1. The said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada. ☐ Yes ☐ No

2. Have the applicant's hospital or teaching duties ever been restricted or limited? ☐ Yes ☐ No *If **YES**, please provide a written explanation.*

3. Was the applicant granted full clinical privileges at your institution? ☐ Yes ☐ No *If **NO**, please provide a written explanation.*

4. Was there any reason not to continue the applicant as an instructor? ☐ Yes ☐ No *If **YES**, please provide a written explanation.*

5. Was the applicant's performance as an instructor consistently rated satisfactory and/or above? ☐ Yes ☐ No
*If **NO**, please provide a written explanation and a copy of the evaluation(s).*

Written Explanation(s): _____

Affix Training Program Seal Here

Name/Title: _____

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

Phone: _____ Fax: _____ Signature: _____