ARIZONA MEDICAL BOARD MEDICAL EMPLOYER VERIFICATION FORM

AUTHORIZATION: The Arizona Medical Board requires all applicants for licensure to obtain verification of all medical employment. This form must be completed by the **Medical Employer** where I have been employed for evaluation of my professional record, mental and physical capabilities, during the five years preceding my application. 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 holds/held the following position: _____

Employment Dates: From: _____ To: _____

Comments, if any: _____

Employer Name: _____ Name/Title: _____

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

Phone: _____ Fax: _____ Signature: _____

Date: _____ (mm/dd/yy)