Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 W Adams Street Phoenix, AZ 85007
Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

RETIRED STATUS RENEWAL APPLICATION

There is no fee to renew your Retired Status

Physician's Name _____ **AZ License Number:** _____

A.R.S. § 32-1832(C) requires a licensee with a Retired license status to renew his/her license every two (2) years. Your renewal is requested by December 31, 2021. You may email or mail this form to the Board office in order to renew your Retired status.

In accordance with A.R.S. § 41-1030 The Board is required to notify you of the following:

B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.
D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.
E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.
F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

1. ADDRESS OF RECORD

Please update your contact information below. If you are volunteering your medical services, you may provide your volunteer practice location in the designated box below. Please note, if you do not provide an address in the volunteer practice address, your mailing address will be your address of record.

Volunteer Practice address, if applicable. ☐ By checking this box, I am requesting the Board use my volunteer practice address as my **mailing address.**			
Name of Practice:			
Street Address:			
Street Address:			
City, State, Zip:			
Office Number:		Fax Number:	
Mailing Address. ☐ Same as above.			
Street Address or P.O. Box:			
City, State, Zip:			
Home Number:			
Cell Number:			
Email Address:			

Your email address is confidential.

Physician's Name _____ **AZ License Number:** _____

THIS PAGE MUST BE COMPLETED AND SIGNED BY THE RENEWING PHYSICIAN

Failure to properly answer the questions below may result in Board disciplinary action including revocation of license.

2. UPDATE PROFESSIONAL CONDUCT HISTORY: If you answer "yes" to any of the following questions, please attach an explanation of the situation on a separate blank sheet of paper. As appropriate, attach copies of documents from hospitals, programs, State Boards, courts and law enforcement agencies confirming your explanation. **During the past two (2) years have you been notified or made aware:**	**YES**	**NO**
A. That you were arrested for, charged with or convicted of a felony, or any misdemeanor that may affect patient safety? You must answer "yes" even if the offense occurred outside of Arizona, the case has not yet been adjudicated, you completed a diversion program, you received a suspended sentence or probation, the convictions were dismissed or set aside, your sentence was commuted, the records were expunged, your civil rights were restored, or you received a pardon.		
B. That you had disciplinary or adverse action imposed against any professional license, or that you were denied a professional license, or that you entered into any consent agreement, stipulated order, or settlement with any regulatory board other than the Arizona Osteopathic Board? Or have you been notified of any complaints or investigations against your license that have not yet been resolved?		
C. That your DEA permit or prescription permit issued by any regulatory board was denied, restricted, suspended, lost, or had any other adverse action taken against it? Or that you have any complaints or investigations against your authority to prescribe that are outstanding or not yet resolved?		
D. That any award, settlement, or payment of any kind was made by you or on your behalf to resolve a civil suit or malpractice claim involving your practice?		
E. That your hospital privileges or healthcare program affiliations were denied, restricted, lost, suspended, or modified, or any other adverse action was taken, even if that action was not required to be reported to the National Practitioner Data Bank? Or are there any unresolved complaints or reviews?		

3. CONFIDENTIAL QUESTIONNAIRE: If you answer "yes" to either of the following questions, you must submit a detailed written narrative statement concerning matter(s) including the name of the 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 five (5) years, pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of doctors of osteopathic medicine impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with compliance reports from the state monitoring programs. **During the past two (2) years have you been notified or made aware:**	**YES**	**NO**
A. That you were diagnosed with or developed initial or worsening symptoms of a physical, mental, or emotional condition that did or may impair or limit your ability to safely practice medicine?		
B. That you entered into a diversion program for treatment and monitoring for substance abuse or dependency, or for correction of communication or boundary issues, in lieu of or as a condition of resolving a matter before a regulatory board, criminal or civil court? You must answer "Yes" even if you received a pardon, the convictions were set aside, the records were expunged, your civil rights were restored and whether or not the sentence was imposed or suspended.		

4. ATTESTATION

☐ I attest I am not engaged in the practice of medicine other than providing services on a volunteer basis no more than ten (10) hours each week or teaching/providing instruction at an approved school of osteopathic medicine.

5. SIGN AND DATE THIS FORM

I, the undersigned, do hereby attest that the information I have provided the Board on this application and in the supporting documentation is true, complete and accurate.

Physician Signature _____ Date signed _____