ARIZONA MEDICAL BOARD
REAPPLICATION FOR TEACHING LICENSE

1740 W. Adams Street, Suite 4000, Phoenix, AZ 85007-2664
www.azmd.gov Email: licensingreport@azmd.gov

REAPPLICATION FOR TEACHING LICENSE 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 subject to the Arizona Medical Practice Act 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.

Please type or legibly print the following information

Name: _____ **AZ Teaching License #** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **E-Mail:** _____

I hereby certify, under penalty of perjury by my signature below that all information on this form is currently accurate and I am a U.S. citizen or a qualified/registered alien.

Signature: _____ **Date:** _____

****Electronic Signature is not acceptable**

QUESTIONNAIRE

1. Since your last application, have you ever had any application for any professional license refused or denied by any licensing authority?	☐ Yes	☐ No
2. Since your last application, have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	☐ Yes	☐ No
3. Since your last application, have you voluntarily surrendered any healthcare license?	☐ Yes	☐ No
4. Since your last application, have you had any healthcare license revoked?	☐ Yes	☐ No
5. Since your last application, have you ever been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	☐ Yes	☐ No
6. Since your last application, 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	☐ No
7. Since your last application, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? "Disciplinary Action includes, but is not limited to, restriction, termination, voluntary or involuntary resignation or withdrawn."	☐ Yes	☐ No
8. Since your last application, have you 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	☐ No
9. Since your last application, have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (See explanation below.) A "yes" answer is required even if you entered a diversion program.	☐ Yes	☐ No
10. Since your last application, have you 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	☐ No
11. Since your last application have you been court martialed or discharged other than honorably from the armed service?	☐ Yes	☐ No
12. Since your last application, have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	☐ Yes	☐ No
13. Since your last application, have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	☐ Yes	☐ No

Note: <u>In the event the response to any of the questions numbered 1 through 13 is 'YES'</u>, you must file with the reapplication, a <u>detailed report</u> 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 matters. IN ADDITION, you must submit photocopies of any corresponding documents, such as complaints or board actions.

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.

Signature: _____ Date: _____ Initials Required: _____

CONFIDENTIAL QUESTIONNAIRE

1. Since your last application, 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	☐ No
2. Since your last application, are you being treated for a drug or alcohol addiction or participated in a rehabilitation program? ***If in a confidential program in another state see explanation below.**	☐ Yes	☐ No
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?	☐ Yes	☐ No

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

a. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;

b. 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

c. 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.

In the event you answer 'YES' to any of the above questions, you must file with the reapplication, a detailed written narrative 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.

Signature: _____ Date: _____ Initials Required: _____

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:_____

PAYMENT CARD AUTHORIZATION
MD TEACHING REAPPLICATION
LICENSE APPLICATION

Please utilize this form if paying with Credit Card.

PLEASE NOTE: The Arizona Medical Board will only accept credit card payment via mail

(USPS, FedEx, UPS, DHL, or any other mail carrier)

Any credit card information received via any other method will not be processed and will be destroyed.

Mail to:
Arizona Medical Board
1740 W Adams St, Suite 4000
Phoenix, AZ 85007

Fee Total: $250

- **$250 Application Fee**

First Name: _____ Last Name: _____

Name as Shown on Payment Card: _____

Cardholder Signature: _____ Date: _____
(Required)

Billing Address of Cardholder: _____
(Required)

City: _____ State: _____ Zip Code: _____

Contact Phone: _____

Mailing Address of Cardholder: _____
(If Different from Billing Address)

City: _____ State: _____ Zip Code: _____

For receipt, please include an email address for submissions: _____

(Official Use Only)

Payment Card Verification (Last 4 Digits)

_____

(Official Use Only Cut Here)

Type of Card: ☐ Visa ☐ Mastercard ☐ Amex

Card Number: _____ Expiration Date: _____

(No Dashes Between Numbers)