ARIZONA MEDICAL BOARD

1740 W. Adams St. Suite. 4000, Phoenix, AZ 85007-2664

POSTGRADUATE TRAINING PERMIT REGISTRATION

(Internship-Residency-Fellowship)

The Board shall grant a one year renewable training permit to a person participating in a teaching hospital's accredited internship, residency or clinical fellowship training program to allow that person to function only in the supervised setting of that program. If a person who is participating in a teaching hospital's accredited internship, residency or clinical fellowship program must repeat or make up time in the program due to resident progression or other issues, the Board may grant that person a training permit if requested to do so by the program's director of medical education or a person who holds an equivalent position. The individual must register with the Board for each year of training and pay the statutory nonrefundable **$50.00** registration fee.

The following information must be completed by the applicant and the licensed hospital which sponsors the accredited training program. This form also applies to applicants applying for a short-term training permit of four months or less. Please submit the registration to the Arizona Medical Board, 1740 W. Adams Street. Suite. 4000, Phoenix, AZ 85007 at least **thirty (30) days prior** to the initiation of the training.

☐ Check this box if this is a renewal for a current Post Graduate Training Permit.

Permit # R _____ Expiration Date: _____

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

Current Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mobile Phone: _____ **Home Phone:** _____ **Email:** _____

Date of Birth (Month, Day, Year): _____ **Birth City:** _____ **State:** _____ **County:** _____

Social Security Number: _____

Please indicate if you would like to designate/authorize ONE other individual beside yourself to receive status updates on your application

Name: _____ **Phone#** _____ **Email:** _____

Citizenship Statement

This form is to be completed by the applicant and is to be submitted for every application, permit or registration that is offered by the Arizona Medical Board, with the exception of the renewal of license if citizenship has previously been established with the Board.

Evidence List

Provide proof of lawful presence in the United States in accordance with A.R.S. § 41-1080 (See Evidence List- as referenced for miscellaneous license application types at www.AZMD.GOV/Physician Center/New Arizona License.).

PROGRAM TO COMPLETE BELOW:

Type of Program: ☐ Internship ☐ Residency ☐ Fellowship

Name of Facility: _____

(Arizona ACGME Approved Hospital or University Name)

Specialty Field: _____

(i.e. Internal Medicine, Gastroenterology, Psychiatry, Family Medicine, etc….)

Permit Dates requested: **From** (m/dd/yr) _____ **To** (m/dd/yy): _____ *Not to exceed one year*

I hereby certify I am authorized to request a postgraduate training permit for the above named facility.

Signature: _____ Title: _____

Name (Printed): _____ Phone Number: _____

Date: _____

Arizona Medical Board: **Permit Issued Date:** _____ **Permit Number:** _____

PAYMENT CARD AUTHORIZATION
POSTGRADUATE TRAINING
PERMIT 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

Please choose from the following:
☐ **$50 Postgraduate Training Permit Fee**
☐ **$50 Postgraduate Training Permit Renewal 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)