ARIZONA MEDICAL BOARD
APPLICATION for TEACHING LICENSE

1740 W. Adams St. Ste. 4000
Phoenix, AZ 85007-2664
Telephone: 480- 551-2700 Toll Free: 877-255-2212
Website: www.azmd.gov

APPLICATION for TEACHING LICENSE in the STATE of ARIZONA

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 not exempt from the requirements of the Arizona Revised Statutes 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.

APPLICATION INSTRUCTIONS and CHECKLIST
(Read Carefully)

In addition to the appropriate completion of the applicable sections of this application, the applicant will submit the following:

1. Evidence of name and date of birth: a copy of U.S. birth certificate, U.S. passport, Permanent resident card, naturalization certificate or visa. (Do not submit originals.)

2. Evidence of U.S. Citizenship, U.S. National Status or Alien Status as required by A.R.S. Sec. 41-1080 (A). Acceptable forms of evidence are contained in the link provided. azmd.gov/PhysicianCenter/NewAZLicense.aspx

3. Signed copy of the Arizona Statement of Citizenship or Alien Status For State Public Benefits. See link provided for the document. azmd.gov/PhysicianCenter/NewAZLicense.aspx

4. Copy of M.D. degree diploma, transcript or letter evidencing applicant graduated from an approved medical school. If applicant graduated from an unapproved school, the application will be submitted to the Board to determine whether the medical education received is the equivalent. The burden of proof is on the applicant to demonstrate the medical education received is the equivalent of an approved school. Applicant may wish to consult A.R.S. Sec.32-1423 for guidance as to the factors the Board may consider when determining equivalency.

5. Check, Money Order or Payment Card Authorization form (see attached) for the nonrefundable fee in the amount of $250 (US dollars only). Applications submitted without the fee will not be processed.

6. Verification of licensure from every state in which the applicant has held a license. Verification must be sent directly from the state licensing board issuing the license and be addressed to the Arizona Medical Board.

7. The Board will, promptly and in writing, notify the applicant of any deficiency in the application that prevents the license from being processed.

8. On request, the Board shall grant an applicant who disagrees with the statement of deficiency a hearing before the Board at its next regular meeting if there is time at that meeting to hear the matter. The Board shall not delay this hearing beyond one regularly scheduled meeting. At any hearing granted pursuant to this subsection, the burden of proof is on the applicant to demonstrate that the alleged deficiencies do not exist.

9. Submit a full set of fingerprints to the board for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

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Official Use Only: **Inquiry #** ________________ **Date Application Received:** ____________________________

(To be completed and signed by applicant. All questions MUST be answered, even if only to indicate "None" or "N/A")

1. **First Name:**

Middle Name:

Last Name:

Other Names Used:

2. **Social Security Number:** *No dashes*

3. **Date of Birth:**

4. **City of Birth:** **State of Birth:**

OR **Country of Birth:**

ADDRESSES:

Practice Address: This is the practice/principal place of business. The address and phone number will appear in the Medical Directory and on the Board's web site. Every physician must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public. If you want your home address to be listed on your web site profile, please so indicate. Otherwise, no address will be be provided on the profile, but it will be provided to the public if requested.

Mailing Address: If no address is provided, all Board correspondence will be sent to the Practice Address.

Email: This address is optional. If you provide an email address, it will not be released to the public.

Home Address: You are required to provide a home address and telephone number. They will not be released to the public *unless* you fail to provide an Office Address.

5.

Practice/Training Name:

Practice/Training Address: **City:** **State:** **Zip:**

Practice Phone: **Practice Fax:**

Mailing Address: **City:** **State:** **Zip:**

EMail:

Home Address: **City:** **State:** **Zip:**

Home Phone: **Mobile Phone:**

6. All states or provinces in which you **have** or **had** a license or registration. If more than five, attach a separate listing. If a license is pending or was not issued, so state. If none, please indicate "Not Applicable."

a. State Board: License No.: Date Issued License Status:

b. State Board: License No.: Date Issued License Status:

c. State Board: License No.: Date Issued License Status:

d. State Board: License No.: Date Issued License Status:

e. State Board: License No.: Date Issued License Status:

7. Medical School Name:

Medical School Location: **Graduation Date:**

If you graduated from a medical school located outside the United States of America or Canada, please list below:

ECFMG No.: Certificate Date:

8. List all hospital affiliations and medical employment for the five years preceding application. Each hospital must verify affiliations or employment on the hospital's official letterhead or the electronic equivalent. **If none, please indicate "Not Applicable".**

a. Name: From: To:

Address: City: State: Zip:

Position Held: ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

b. Name: From: To:

Address: City: State: Zip:

Position Held: ☐ **Hospital Affiliation** ***and/or*** ☐ **Medical Employment**

QUESTIONNAIRE

Question		
1. Have you ever had any application for any professional license refused or denied by any licensing authority?	☐ Yes	☐ No
2. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	☐ Yes	☐ No
3. Have you ever been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled?	☐ Yes	☐ No
4. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently?	☐ Yes	☐ No
5. Have you ever voluntarily surrendered any healthcare license?	☐ Yes	☐ No
6. Have you ever had any healthcare license revoked?	☐ Yes	☐ No
7. Have you ever been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	☐ Yes	☐ No
8. 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
9. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.	☐ Yes	☐ No
10. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	☐ Yes	☐ No
11. Have you ever 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
12. Have you ever 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
13. Have you ever 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
14. In the last ten (10) years has a judgment or settlement been entered against you as a defendant in a medical malpractice suit? ***Please DO NOT report pending malpractice suits or settlements paid not related to a civil action.**	☐ Yes	☐ No
15. Have you ever been court martialed or discharged other than honorably from the armed service?	☐ Yes	☐ No
16. Have you ever been terminated from a healthcare position with a city, county, or state government or the Federal government?	☐ Yes	☐ No
17. Have you ever 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: In the event the response to any of the questions numbered 10 through 26 is "YES"*, the applicant must file with the application a detailed report 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 charge(s). IN ADDITION, the applicant must submit photocopies of any complaints, hearings, settlements or judgments together with copies of patient's hospital and/or office records to the AMB.**

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.

CONFIDENTIAL
PHYSICIAN HEALTH PROGRAM

Question	Yes	No
1. Within the last five years, 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. Are you now being treated or have you in the last 5 years been 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/ r (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? **See below for definition of ability to practice medicine**.	☐ Yes	☐ No

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

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

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

2. 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

3. 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.

(THIS SECTION INTENTIONALLY LEFT BLANK)

Applicant Name ____________________ Date ____________________

The applicant [ ]

(PRINT OR TYPE YOUR FULL AND COMPLETE NAME)

being first duly sworn upon his oath deposes and says: that I am the person herein named subscribing to this application; that I have read the statutes and rules regarding licensure and have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Arizona Medical Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Arizona Medical Board or its successors to release to the organizations, individuals or groups listed above any information which is material to the application or any subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

☐ **I am a U.S. Citizen or U.S. National.** (If this box is checked, please submit with your application a certified copy of your Birth Certificate or U.S. Passport.)*

☐ **I am NOT a U.S. Citizen or U.S. National.** (If this box is checked, please submit with your application a copy of your permanent resident card or Visa.)*

*See Statement of Citizenship form for complete list of accepted documents available on the website at azmd.gov/PhysicianCenter/NewAZLicense.aspx

Signature of Applicant [ ] Date: [ ]

If you would like to designate/authorize ONE other individual beside yourself to check the status of your application with the AMB, please complete the following information:

Individual Name [ ] Phone # [ ] Date [ ]

* ARIZONA LAW REQUIRES AN APPLICANT WHO HAS BEEN CHARGED WITH A FELONY OR A MISDEMEANOR INVOLVING CONDUCT THAT MAY AFFECT PATIENT SAFETY AFTER SUBMITTING THE APPLICTION TO NOTIFY THE AMB WITHIN 10 DAYS AFTER THE CHARGE IS FILED.

ARIZONA REVISED STATUTE (A.R.S.) §32-3208 (SEE WEBSITE UNDER *Regulation-Reportable Criminal Charges- Reportable Misdemeanors* FOR LIST OF REPORTABLE MISDEMEANORS - ALL FELONIES ARE REPORTABLE.)

ARIZONA MEDICAL BOARD
MALPRACTICE ADDENDUM

1740 W. Adams St. Ste. 4000
Phoenix, AZ 85007-2664
Telephone: 480- 551-2700 Toll Free: 877-255-2212
Website: www.azmd.gov; LicensingReports@azmd.gov

(Complete this form if you answered YES to question #23 on the application.)

The applicant must complete this form for each malpractice settlement or judgment in the last ten (10) years. If more than one case, please make copies of this form and return with required documents. Please report only the settlement of a civil action.

Applicant Name ______________________

1. **On a separate sheet of paper type your full name and provide a detailed clinical narrative regarding each malpractice case(s). Include name of patient, age, sex, date of occurrence and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description that includes all of the facts requested above.** ***NOTE:*** **HIPAA regulations do not prevent you from responding and providing the requested information.**

2. **Indicate your position in case, i.e., intern, resident, primary doctor, etc.**

   ____

3. **Case was filed against:** ☐ Individual Doctor ☐ Group ☐ Hospital

4. **What was the amount and date of the judgment or settlement?** Amount ________ Date ________

5. **Amount of judgment or settlement attributed to you** Amount ________

6. **Has this case been investigated or reviewed by any State Medical Board?** ☐ Yes ☐ No
   If answer is "Yes", request letter of resolution from State Medical Board be sent directly to us. You do not need to attach the documents listed below if the case has been investigated or reviewed by any State Medical Board.

You are required to attach the following for each case:

- ☐ **Copy of plaintiff's complaint**
- ☐ **Copy of Judgment or Settlement Agreement**
- ☐ **Copy of complete set of medical records including x-rays or diagnostic films**

*** X-rays and diagnostic films must be included. Your application cannot be processed without them.**

I certify that the information which I have provided is correct to the best of my knowledge.

Signature ______________________ Date ________

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 ____

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 ______________________________________ Date: ____________________

Typed/Printed Name of Dean/Director ____

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 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)