Arizona Medical Board

1740 W. Adams St. Ste. 4000

Phoenix, AZ 85007-2664

Telephone: 480- 551-2700 Toll Free: 877-255-2212

Website: www.azmd.gov

Email: LicensingReport@azmd.gov

A.R.S. § 32-1438: Temporary licensure; requirements; fees

A. Beginning July 1, 2017, the board may issue a temporary license, which may not be renewed or extended, to allow a physician who is not a licensee to practice in this state for a total of up to two hundred fifty consecutive days if the physician meets all of the following requirements:

1. **Holds an active and unrestricted license to practice medicine in a state, territory or possession of the United States.**
2. **Has applied for a license pursuant to section § 32-1422 and meets the requirements specified in A.R.S. § 32-1422, subsection A, paragraphs 1 through 7.**
3. **Has paid any applicable fees.**

B. The physician shall submit to the board a notarized affidavit attesting that the physician meets the requirements of subsection A, paragraphs 1, 2 of this section. The physician shall notify the board immediately if any circumstance specified in subsection A, paragraphs 1, 2 of this section changes during the application period for a temporary license or while holding a temporary license, at which time the board may deny or revoke the temporary license. The board may suspend, deny or revoke a temporary license and withdraw the application for initial licensure if the applicant has made a misrepresentation in the attestation required by this section or any other portion of the application pursuant to this chapter.

C. The board shall approve or deny an application under this section within thirty days after an applicant files a complete application. The approval of a temporary license pursuant to this section allows the physician to practice in this state without restriction.

D. If granted, the physician's temporary license expires the earlier of two hundred fifty days after the date the temporary license is granted or on approval or denial of the physician's license application submitted pursuant to section A.R.S. § 32-1422.

E. For the purpose of meeting the requirements of subsection A of this section, an applicant shall provide the board the name of each state, territory or possession of the United States in which the person is licensed or has held a license and the board shall verify with the applicable regulatory board that the applicant holds an active and unrestricted license to practice medicine, and has never had a license revoked or suspended or surrendered a license for disciplinary reasons. An applicant shall also provide the board with all medical employment as required by A.R.S. § 32-1422, subsection A. The board may accept the verification of this information from each other regulatory board verbally, in writing or through the use of the other regulatory board's website, which shall be followed by either an electronic or hard copy of the verification required by A.R.S. § 32-1422, subsection F before the physician's permanent license is granted. If the board is unable to verify the information within the initial thirty days as required by subsection C of this section, the board may extend the time frame by an additional thirty days to receive the necessary verification.

F. The board may establish a fee in rule for temporary licensure under this section.

Please be advised that application fees are non-refundable. Therefore, the Agency recommends that applicants check with prospective employers regarding whether a temporary license is acceptable prior to filing an application.

Arizona Medical Board

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

A.R.S. § 32-1422: Basic requirements for granting a license to practice medicine;

A. An applicant for a license to practice medicine in this state pursuant to this article shall meet each of the following basic requirements:

1. Graduate from an approved school of medicine or receive a medical education that the board deems to be of equivalent quality.

2. Successfully complete an approved twelve-month hospital internship, residency or clinical fellowship program.

3. Have the physical and mental capability to safely engage in the practice of medicine.

4. Have a professional record that indicates that the applicant has not committed any act or engaged in any conduct that would constitute grounds for disciplinary action against a licensee under this chapter.

5. Not have had a license to practice medicine revoked by a medical regulatory board in another jurisdiction in the United States for an act that occurred in that jurisdiction that constitutes unprofessional conduct pursuant to this chapter.

6. Not be currently under investigation, suspension or restriction by a medical regulatory board in another jurisdiction in the United States for an act that occurred in that jurisdiction and that constitutes unprofessional conduct pursuant to this chapter. If the applicant is under investigation by a medical regulatory board in another jurisdiction, the board shall suspend the application process and may not issue or deny a license to the applicant until the investigation is resolved.

7. Not have surrendered a license to practice medicine in lieu of disciplinary action by a medical regulatory board in another jurisdiction in the United States for an act that occurred in that jurisdiction and that constitutes unprofessional conduct pursuant to this chapter.

8. Pay all fees required by the board.

9. Complete the application as required by the board.

10. Complete a training unit as prescribed by the board relating to the requirements of this chapter and board rules. The applicant shall submit proof with the application form of having completed the training unit.

11. Have submitted directly to the board, electronically or by hard copy, verification of the following:

(a) Licensure from every state in which the applicant has ever held a medical license.

(b) All medical employment for the five years preceding application. If the applicant is employed by a hospital or medical group or organization, the board shall accept the confirmation required under this subdivision from the applicant's employer. For the purposes of this subdivision, medical employment includes all medical professional activities.

12. Have submitted 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.

ARIZONA MEDICAL BOARD
MD TEMPORARY LICENSE APPLICATION

1740 W. Adams St. Ste. 4000
Phoenix, AZ 85007-2664
Website: www.azmd.gov

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

Personal Information

1. First Name: _____ **3. Date of Birth:** _____

Middle Name: _____

Last Name: _____

Other Names Used: _____

2. Social Security Number: _____

Social Security Number and Date of Birth are Confidential Information - Not for Public Disclosure

Address Information

Practice Address: This is the practice/principal place of your business. The address and phone number provided will appear in the Medical Directory and on the Board's website. **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 upon request. If you want your home address to be listed as your practice address on the Board's website, include the address in the practice address field.

4. Practice/Training Name: _____

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

Phone: _____ **Fax:** _____ ***Practice address not required for licensure**

Home Address: You are **required** to provide a home address, telephone number and email address. Your home address and telephone number will not be released to the public *unless* you fail to provide a practice address. Your email address will not be released to the public.

5. Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Mobile:** _____

Primary Email Address: _____

Mailing Address: If no address is provided, all Board correspondence will be sent to your practice address. **Please note** - Your fingerprint packet will be sent to your mailing address.

6. Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

☐ Same as Practice Address ☐ Same as Home Address

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

7. Medical Employment

Please answer all questions and list all employment, to include all medical professional activities for the five years preceding the date of the application. List all physician placement groups related to employment, emergency medical groups, radiology groups, etc.

Please list N/A if you're currently in postgraduate training. **Do not list your postgraduate training below. This form must be completed.**

a. Name: From: To:

Address: City: State: Zip:

Position Held: Employer Phone No.

---

b. Name: From: To:

Address: City: State: Zip:

Position Held: Employer Phone No.

---

c. Name: From: To:

Address: City: State: Zip:

Position Held: Employer Phone No.

---

d. Name: From: To:

Address: City: State: Zip:

Position Held: Employer Phone No.

---

e. Name: From: To:

Address: City: State: Zip:

Position Held: Employer Phone No.

---

f. Name: From: To:

Address: City: State: Zip:

Position Held: Employer Phone No.

First Name: **Last Name:**

8. Other State Medical License(s)

Please list all states, provinces or U.S. territories in which you have been granted a license or registration to practice medicine, including license number, date issued and current status of the license (active, lapsed, inactive, etc.). If more than 10, attach a separate listing.

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

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

READ EACH OF THE FOLLOWING ITEMS CAREFULLY

When finished, please initial next to each.

9. Acknowledgements

To qualify for a Temporary License under A.R.S. § 32-1438(A) I acknowledge: 1. I must hold an active and unrestricted license to practice medicine in a state, territory or possession of the United States. 2. I have applied for a full MD license pursuant to section A.R.S. § 32-1422 and meet the requirements specified in A.R.S. § 32-1422, subsection A paragraphs 1-7.	Initial:
I acknowledge that if any of the circumstances specified in A.R.S. § 32-1438, subsection A, paragraphs 1 and 2 change during the application period, or while I hold a Temporary License, I must promptly notify the Arizona Medical Board.	Initial:
I acknowledge that the Arizona Medical Board may deny, suspend or revoke the Temporary License at any time, if I have misrepresented any of the information provided in this application.	Initial:

10. Attestation

I attest that all of the information contained in the application and accompanying evidence or other credentials submitted are true. I attest the credentials submitted with the application were procured without fraud or misrepresentation or any mistake of which I am aware, and that I am the lawful holder of the credentials. I authorize the release of any information from any source requested by the Board necessary for initial and continued licensure in this state.

Signature of Applicant: _____ Date: _____

Notarization

Subscribed and sworn in front of me by_____, personally appearing on this date_____.
Applicant Name

_____
Notary Public's Signature

(Personalized Seal)

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

PAYMENT CARD AUTHORIZATION
MD TEMPORARY 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)