



ARIZONA MEDICAL BOARD CLINICAL INSTRUCTOR VERIFICATION FORM

AUTHORIZATION: The Arizona Medical Board requires all applicants for licensure to obtain verification of all hospitals where they have been employed as a clinical instructor. This form must be completed by the **Program Director**. This is authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board. Authorization may be sent via mail or fax to 1740 W. Adams St. Ste. 4000, Phoenix, AZ 85007 or (480) 551-2704.

First Name: Last Name:
Signature: Date:

This is to certify that the applicant listed above was a full time (rank, i.e. assistant professor)
in the (type of program) at (name of school)
Located in: City: State: in the field of:
From: To:

1. The applicant has served as a full-time assistant professor or in a higher position in an approved school of medicine for a minimum of 36 months? Yes No
2. Have the applicant's hospital or teaching duties ever been restricted or limited? Yes No *If YES, please provide a written explanation.*
3. Was the applicant granted full clinical privileges at your institution? Yes No *If NO, please provide a written explanation.*
4. Was there any reason not to continue the applicant as an instructor? Yes No *If YES, please provide a written explanation.*
5. Was the applicant's performance as an instructor consistently rated satisfactory and/or above? Yes No *If NO, please provide a written explanation and a copy of the evaluation(s).*

Written Explanation(s):

Name/Title:
Address: City: State: Zip:
Phone: Fax: Signature:

