Arizona Medical Board
Arizona Regulatory Board of Physician Assistants
LICENSE VERIFICATION REQUEST FORM

Please Note: All full MD license verifications that are to be sent only to another state medical board will be processed by Veridoc. Please click on the following link for full MD license verifications to be sent to another state medical board: www.veridoc.org

The Board will continue to provide license verifications for all other verification requests including full MD verifications not being sent to another state medical board, Post Graduate Training Permits, Transition Training License, Pro Bono, Teaching Certificates, Temporary License, Locum Tenens and PA Licenses. Please fill out and submit the following form for all other license verification requests.

Licensee Name: _____ **Licensee Date of Birth** (if known): _____ **Licensee No.** (if known): _____

Requestor's Name (if different than licensee): _____

Requestor's Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number (if there are questions pertaining to your request): _____

Type of Arizona License to be Verified:

- ☐ M.D. (Only if verification is not being sent to another state board).
- ☐ M.D. Resident/ Post-Graduate Training Permit/ Transitional Training Permit
- ☐ M.D. Locum Tenens
- ☐ M.D. Pro Bono License
- ☐ M.D. Teaching License
- ☐ M.D. Temporary License
- ☐ M.D. Telehealth License
- ☐ P.A. License
- ☐ P.A. Temporary License

Name of the Board/Organization where the verification will be sent: _____

Delivery Method *(Select **One**)*: ☐ **Mail** (Please fill out mailing address)

Attention To: _____

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

☐ **Fax** (Please contact the Board/Organization prior to selecting this option to ensure they accept faxed verifications)

Fax Number: _____ ☐ **Other**: (Specify delivery method): _____

Payment Method *(Select **One**)*:

☐ Check (Enclose with this form. Make payable to Arizona Medical Board)

☐ Credit Card (Please fill out credit card payment form and return with this Verification Request Form)

Please mail the completed license verification request form to:

Arizona Medical Board
Attn: Verifications
1740 W. Adams St, Suite 4000
Phoenix, AZ 85007

Note: There is a $10 fee per license verification. If payment does not accompany this form, the verification request will not be processed and will be returned to the requestor. The Board is not responsible for verifications that have been processed and sent, but not received by the intended recipient. There is a $10 fee for verifications that must be re-sent. A method of delivery which provides tracking service, such as FedEx, is recommended to ensure receipt.

PAYMENT CARD AUTHORIZATION
LICENSE VERIFICATION

Please complete this form and attach your verification request form if paying with Credit Card or check.
If paying by check, return the invoice with check or money order to the address listed below.

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: $10
- **$10 Application Fee**

Payment for: _____ License Number: _____
(First and 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: _____

(Official Use Only)

Payment Card Verification (Last 4 Digits) _____

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

Type of Card: ☐ Visa ☐ Mastercard ☐ Amex

Card Number: _____ Expiration Date: _____