



**Arizona Medical Board**  
**Arizona Regulatory Board of Physician Assistants**  
 1740 W. Adams St, Suite 4000, Phoenix, AZ 85007  
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### PUBLIC INFORMATION REQUEST FORM

**Contact Name:**  **Date:**

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

**Phone Number**  **E-mail Address:** \_\_\_\_\_

#### Public Information Requested

**License Files:**  
*List physician or physician assistant name or license number.*

**Board Meetings:**  
*List agendas or minutes and meeting dates.*

**Board Actions:**  
*List physician or physician assistant name or Case number.*

**If Applicable:  
 Formal Hearing Documents**

**Please check one of the following:**

I want to receive the documents via e-mail at no cost. **E-mail Address\*:** \_\_\_\_\_ **\*Required Field**

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