



**Arizona Board of Osteopathic Examiners In Medicine and Surgery**

9535 E. Doubletree Ranch Road, Scottsdale, AZ 85258-5572

Ph : 480-657-7703 | Fx: 480-657-7715 | [www.azdo.gov](http://www.azdo.gov) | [questions@azdo.gov](mailto:questions@azdo.gov)

**LICENSE RENEWAL APPLICATION TO PRACTICE IN CALENDAR YEARS 2011 AND 2012**

Biennial Renewal Fee: \$636.00 (if postmarked by January 31, 2011)

\$811.00 (if postmarked between Feb 1 and April 30, 2011)

**For Paper Renewals, expect to receive your wallet card within 30 working days**

*If you wish to receive your wallet card within 10 working days, please use the Online Renewal at [www.azdo.gov](http://www.azdo.gov) > For DOs >*

|  |  |
|--|--|
|  |  |
| <p><b>Address of Record/Practice Address.</b> This address &amp; phone number is required by ARS § 32-1803(4)(b), and shows on the Board's website. <b>This address will be your mailing address unless you designate otherwise in the residential address box to the right.</b></p> | <p><b>Residential Address.</b> <input type="checkbox"/> <b>By checking this box I am requesting that the Board use my Residential address as my mailing address.</b> Your home address and phone is required and your home <u>city and state only</u> will show on the Board's website if you do not provide a practice address (ARS § 32-1800(2)(b) &amp; ARS § 32-3801).</p> |
| Name of Practice:  | Street Address:  |
| Street Address:  | City, State, Zip:  |
| City, State, Zip:  | Home Number:   |
| Office Number:   | Cell Number:   |
| Fax Number:  | Email Address:   |

**2. SPECIALTY / AREA OF PRACTICE:** List all specialties or practice areas below. If you are Board certified by AOA-BOS or ABMS, check the box in the correct column to indicate this, and fill in the certified and expiration dates. If you do not check any boxes, only your specialty / area of practice will show on your website profile. The Board recognizes certification from only the American Osteopathic Association Board of Specialties (AOA-BOS) and the American Medical Board Specialties (ABMS).

| Name of Specialty<br>(Refer to listing of specialties at <a href="http://www.azdo.gov">www.azdo.gov</a> ) | Specialty Organization<br>(check one) |      | Date<br>awarded | Date<br>expires |
|---|---------------------------------------|------|-----------------|-----------------|
|   | AOA-BOS                               | ABMS |                 |                 |
|   |                                       |      |                 |                 |
|   |                                       |      |                 |                 |
|   |                                       |      |                 |                 |

Physician's Name \_\_\_\_\_

AZ License Number: \_\_\_\_\_

**THIS PAGE MUST BE COMPLETED AND SIGNED BY THE RENEWING PHYSICIAN**

| <b>3. UPDATE ON PROFESSIONAL CONDUCT HISTORY:</b><br>Check "yes" or "no." If you check YES, please attach an explanation on a separate piece of paper and supporting documents. <b>Since your initial application or last renewal (whichever is more recent), have you been notified or made aware:</b> | YES | NO |
|---|-----|----|
| 1. That you were diagnosed with or developed initial or worsening symptoms of a physical, mental, or emotional condition that did or may impair or limit your ability to safely practice medicine?  |     |    |
| 2. That you were charged with or convicted, pardoned or had a record expunged or vacated of a felony or misdemeanor involving moral turpitude?  |     |    |
| 3. That you had any disciplinary or adverse action imposed against any professional license, that you were denied a professional license, or that you entered into any consent agreement, stipulated order, or settlement with any regulatory board other than the AZ Osteopathic Board?                |     |    |
| 4. That you entered into a diversion program for treatment and monitoring for substance abuse or dependency, or for correction of communication or boundary issues, in lieu of or as a condition of resolving a matter before a regulatory board, criminal or civil court?                              |     |    |
| 5. That your DEA permit or prescription permit issued by any regulatory board was denied, restricted, suspended, lost, or had any other adverse action taken against it?  |     |    |
| 6. That any award, settlement, or payment of any kind was made by you or on your behalf to resolve a civil suit or malpractice claim involving your practice?   |     |    |
| 7. That your hospital privileges were denied, restricted, lost, suspended or modified, or any other adverse action was taken, even if that action was not required to be reported to the National Practitioner Data Bank?   |     |    |

**4. COMPLIANCE WITH CME REQUIREMENT**

I have NOT been noticed for CME Audit

\_\_\_\_\_ I am in compliance with the CME requirement. I have completed at least 20 hours of CME which included at least 12 hours of Category 1A CME and no more than 8 hours of Category 1 CME during each of the calendar years 2009 and 2010 or during an approved extension period.

I have been noticed for CME Audit

\_\_\_\_\_ I am in compliance with the CME requirement. I have attached a listing of my completed CME with this application on the CME Audit Listing Form & included the AOA's CME Transcript OR all Certificates of Completion with my Renewal.

**The CME FAQ, CME Audit Form and Forms for Extensions and/or Waivers of CME are available on the Board's website [www.azdo.gov](http://www.azdo.gov) > For DOs > Paper License Renewal**

**5. SIGN AND DATE THIS FORM**

I, the undersigned, do hereby attest that the information I have provided the Board on this application and in the supporting documentation is true, complete, and accurate.

Signature \_\_\_\_\_ Date signed \_\_\_\_\_

*License holder must sign the form; If filling out electronically, valid electronic signatures are accepted.  
Stamped signatures are not valid and not accepted.*

**Please include the completed Credit Card Payment form,  
Or make your check payable to "AZ Osteopathic Board"**

**WORKFORCE SURVEY OF OSTEOPATHIC PHYSICIANS**

The Arizona State University Center for Health Information and Research, in collaboration with the Arizona Osteopathic Board is conducting this survey to gather research and form State policy regarding health information technologies in Arizona.

Name: \_\_\_\_\_, DO AZ License #: \_\_\_\_\_

1. How would you best characterize your practice? (Please do not check more than two)  Fully Retired (skip to end)  Semi-retired/ On Leave

- Med School, Intern, Resident, Fellow  Government (VA, HIS, etc/)  Administrative Medicine  Community Health Center  
 Hospitalist  Group Practice  Solo Practice  Academic/Teaching/Research

2. Which of the following are available in your practice location? (check all that apply)

- Email  Internet (Web)  Fax  Medifax  None of the above

3. How do you submit your bills to payers? (check all that apply)

- Email  Via Internet  Fax  U S Mail  Don't Know

4. Are patient's medical records in your practice/organization stored as:

A. Paper Files  Yes  No Scanned Images of Paper Files  Yes  No

B. Electronic files (electronic medical records) on PC or Central Server  Yes  No (if no, skip to #5)

1. Are the records stored on:  PC/server located in your organization or

on a server which you connect via the internet?  Don't Know

2. Is your EMR system connected to: (check all that apply)

a.  Hospital  Pharmacy  Lab  Radiology center  None of these

3. Are you the person who decided to purchase an electronic medical record system?

a  Sole Decision Maker  Shared Decision  Decided by others

b. What is a reasonable amount to pay for an electronic medical record system (per individual provider within a practice setting)?

\$5000-10,000/provider  \$10,000-20,000/provider  > \$20,000 per provider (go to question #6)

5. Are you the person who would decide to purchase an electronic medical record system?

A.  Sole Decision Maker  Shared Decision  Decided by others (skip to end)

B. Would you consider an internet-based system (patient records stored offsite) rather than one where the

records are stored in your office PC or server?  Yes  No

C. What is a reasonable amount to pay for an electronic medical record system (per provider within a practice setting)?

\$5000-\$10,000/provider  \$10,000-\$20,000/provider  >\$20,000 per provider

6. Would you be willing to participate in a web based system that permits exchanges of medical records among health care providers?

Yes  No (skip to end)

A. Who would you trust to manage a health information exchange system? (check all that apply)

Conventional vendor  Health insurer/managed care plan  Hospital system  State of Arizona (AHCCCS)

Regional health information organization (RHIO)  Other

PLEASE SEND ME A COPY OF THE RESULTS

-----  
Thank you for completing this survey



**Arizona Board of Osteopathic Examiners In Medicine and Surgery**  
9535 E. Doubletree Ranch Road, Scottsdale, AZ 85258-5572  
Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

### CREDIT CARD PAYMENT FORM

Name of Physician \_\_\_\_\_ AZ Lic No. \_\_\_\_\_

**PLEASE COMPLETE AND RETURN THIS FORM IF PAYING BY CREDIT/DEBIT CARD**

This form and your order/application may be faxed to: 480-657-7715  
*If faxing this form, please do not mail the original as you may be charged twice.*

Payment Amount: \$ \_\_\_\_\_

Type of Card:  Visa  MasterCard  American Express

Visa or MasterCard #:  -  -  -

OR

American Express #:  -  -

Expiration Date: \_\_\_\_\_ /  (Month Name/YY)

Name as Shown on Credit/Debit Card: \_\_\_\_\_

**Billing Address: (Required)**

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number of Card Holder: (Required) \_\_\_\_\_

**Mailing Address (Required if different from billing address)**

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number of Card Holder: (Required) \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_ Date: \_\_\_\_\_

*Note: The Board shreds this form after payment has been authorized by your credit card company*