



Arizona Board of Osteopathic Examiners In Medicine and Surgery

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LICENSE RENEWAL APPLICATION TO PRACTICE IN CALENDAR YEARS 2012 AND 2013

Biennial Renewal Fee: \$636.00 (if postmarked by January 31, 2012)
 \$811.00 (if postmarked between Feb 1 and April 30, 2012)

For Paper Renewals, (delivery, fax or email submissions) expect to receive your wallet card within 30 days

If you wish to receive your wallet card within 10 working days, please use the Online Renewal at www.azdo.gov > For DOs > On-line License Renewal

Physician's Name _____ AZ License Number: _____

1. ADDRESSES: The Osteopathic Statutes require that you provide BOTH the address where you practice AND your home address. Your practice will be your mailing address unless you check the box for the Residential address. Please list the email you would like the Board to use to communicate with you. Email addresses are not published.

Address of Record/Practice Address. This address & phone number is required by ARS § 32-1803(4)(b), and shows on the Board's website. This address will be your mailing address unless you designate otherwise in the residential address box to the right.		Residential Address. <input type="checkbox"/> By checking this box I am requesting that the Board use my Residential address as my mailing address. 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) & ARS § 32-3801).	
Name of Practice:		Street Address:	
Street Address:		City, State, Zip:	
City, State, Zip:		Home Number:	
Office Number:	Fax Number:	Cell Number:	
Work Email Address:		Email Address:	

2. SPECIALTY / AREA OF PRACTICE: Please review your profile on our website at www.azdo.gov > Doctor Search. If there are any changes to your profile, please list them here. If you have become board certified in your specialty since licensure or your last renewal, whichever is most recent, please list your certification below and include a copy of your certificate or letter from your certifying board. This board only recognizes American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) and the American Medical Board Specialties (ABMS).

Name of Specialty (Refer to listing of specialties at www.azdo.gov)	Specialty Organization (check one)		Date awarded	Date expires
	AOA-BOS	ABMS		

Physician's Name _____

AZ License Number: _____

THIS PAGE MUST BE COMPLETED AND SIGNED BY THE RENEWING PHYSICIAN

3. UPDATE ON PROFESSIONAL CONDUCT HISTORY: Check "yes" or "no." If you check YES, please attach an explanation on a separate piece of paper and supporting documents. Since your initial application or last renewal (whichever is more recent), have you been notified or made aware:	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 2010 and 2011 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 > 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.

Physician Signature _____ Date signed _____

License holder must sign the form. Electronic or stamped signatures are not valid and not accepted.

***Please include the completed Credit Card Payment form with your application,
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



CREDIT CARD PAYMENT FORM

Physician Name: _____ AZ Lic No.: _____

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

If you filed an extension on or before January 31st, or are renewing by January 31st, renewal fee is \$636.00.

If you are renewing your license AFTER January 31st, you must pay the late fee of \$175.00 in addition to the \$636.00 renewal fee.
 The total owed to renew AFTER January 31st is \$811.00.

PAYMENT AMOUNT:
On or before January 31st: \$ 636.00
After Jan 31st: \$ 811.00

Type of Card: Visa MasterCard American Express

Visa or MasterCard #: _____ - _____ - _____ - _____

OR

American Express #: _____ - _____ - _____

Expiration Date: _____ / _____ (MM/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

This form and your renewal application may be faxed to the Board at 480-657-7715