

INTERNSHIP-RESIDENCY-FELLOWSHIP PROGRAM CERTIFICATION

Type of Post Graduate Training Program: Internship Residency Fellowship

This is to certify that _____, D.O.,

will be engaged in an accredited training program in the field of _____ at

Full Name of Training Program: _____

Address: _____ State _____ Zip _____

Phone Number: _____

The program COMMENCED on (month/day/year): _____

and the anticipated date of completion is (month/day/year): _____.

This specific request for permit is for the dates of _____ through _____.

Please answer the questions below. If the answer to either question is YES, please attach a written explanation:

1. Have any actions, restrictions, limitations (including probation or academic probation) been taken while the applicant was participating in any training program? Yes No
2. Does the applicant have any disability which may affect his/her ability to safely engage in the practice of medicine? Yes No

I certify that the program is accredited by the AOA or the ACGME and certify that the answers to the above statements in this application are true and correct:

Signature: _____

Printed Name: _____

SEAL

Title: _____

Date: _____

Should the postgraduate trainer be terminated from the program at any time, the facility must notify the Board immediately. Upon termination from the program, the postgraduate training permit holder no longer has valid credentials and may no longer practice medicine in Arizona. Should the facility wish to allow the postgraduate trainer to rejoin the program, a new application must be filed.



ARIZONA BOARD OF OSTEOPATHIC EXAMINERS

**PAYMENT CARD AUTHORIZATION
OSTEOPATHIC POSTGRADUATE TRAINING RENEWAL REGISTRATION FEE**

Payment for: _____, D.O.

FEE: \$53.00

Type of Card: Visa MasterCard

Card #: - - -

Expiration Date: / (MM/YY)

Name as Shown on Payment Card: _____

Billing Address: (Required)

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number of Card Holder: (Required) _____

Mailing Address: (If different from billing address)

Street Address: _____

City: _____ State: _____ Zip: _____

Signature of Card Holder: _____ Date: _____

Please complete and return this form *with your application and all necessary documents* if paying by credit card.

This form and the application may be faxed to: 480-657-7715

If faxing this form, please do not mail the original as you may be charged twice.

OR

You may mail the form and application to:
**Arizona Board of Osteopathic Examiners
9535 E. Doubletree Ranch Road
Scottsdale, AZ 95258**