

THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY

9535 E. DOUBLETREE RANCH ROAD
SCOTTSDALE, AZ 85258-5539
(480) 657-7703
FAX (480) 657-7715
www.azosteoboard.org

Attach a photograph
for identification purposes
Approximately
2 1/2" x 2 1/2"
TAKEN WITHIN THE
PAST SIXTY (60) DAYS

THIS AREA FOR OFFICIAL USE ONLY

90 DAY LOCUM TENENS REGISTRATION TO PRACTICE MEDICINE

The filing of this application does not grant any special privilege to open an office or to conduct any method of treating the sick or afflicted in the State of Arizona, nor does it imply or guarantee that a regular license to practice osteopathic medicine and surgery in Arizona will be granted upon application.

SECTION I: IDENTIFICATION AND CONTACT INFORMATION

Last Name			First Name			Middle Name		
Current Address (if your address changes during the processing of this application, notify the Board ASAP)								
Daytime Phone Number					Email Address			
Other Names Used (Provide COPIES of marriage license, court records, etc, to verify change.)								
Citizenship: U.S. Citizen: _____			Resident Alien: _____			Other: _____		
Height: _____		Weight: _____		Eye Color: _____		Hair Color: _____		
Confidential information								
Date of Birth: _____				Social Security Number: _____				

SECTION IA: SPONSORING PHYSICIAN

Name of Sponsoring Physician: _____
Name of Company: _____
Address: _____
Phone Number: _____
Exact Requested Dates of Locum Tenens (not longer than 90 days): _____ to _____

SECTION II: LICENSES AND PRACTICE Please fill in the information for each license you hold or have held. If you were previously licensed in AZ, list that, too. List the state where you were first licensed in the first box, marked (F). On a separate piece of paper, explain any time you were not in practice You must request that each State listed (except AZ) send a verification of license directly to the AZ Board of Osteopathic Examiners, or must include a recent print-out of that State's website verification of your license status.

Issuing State (attach additional sheets if needed)	License Number	Date of Issuance	Date of Expiration	Year first practiced there	Year last practiced there
(F)					

SECTION III: EDUCATION HISTORY Please fill out completely.

	Name of Institution	City/State	Years Attended From/ To
Osteopathic College			
Internship			
Residency			
Fellowship			
Preceptorship			
Other			

SECTION V: PROFESSIONAL CONDUCT HISTORY

If you answer "yes" to any of the following questions, please attach an explanation of the situation on a separate sheet. As appropriate, attach copies of documents from hospitals, programs, State Boards, courts, and law enforcement agencies confirming your explanation.	YES	NO
1. Have you been diagnosed with or developed initial or worsening symptoms of a physical, mental, or emotional condition which did or may impair or limit your ability to safely practice medicine?		
2. Have you been convicted of, pled guilty or no contest to any felony or to a reportable misdemeanor; OR that are you under investigation for or have been arrested for or charged with any felony or any misdemeanor that may affect patient safety, even if the case has not yet been adjudicated?		
3. Have you had any disciplinary or adverse action imposed against any professional license, or were you denied a professional license, or have you entered into any consent agreement, stipulated order, or settlement with any regulatory board; OR have you have been notified of any complaints or investigations against your license that have not yet been resolved?		
4. Have you entered into a diversion program for evaluation, treatment, or 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; OR have you been notified that such action is pending?		
5. Has your DEA permit or prescription permit issued by any regulatory board been denied, restricted, suspended, lost, or had any other adverse action taken against it, OR have you been notified of any complaints or investigations against your authority to prescribe that have not yet been resolved?		
6. Has any award, settlement, or payment of any kind been made by you or on your behalf to resolve a civil suit or malpractice claim involving your practice, even if it was not required to be reported to the National Practitioner Data Bank; OR have you been notified that any such suit or claim is pending?		
7. Have your hospital privileges or health care program affiliations denied, restricted, lost, suspended or modified, or subjected to any other adverse action, even if that action was not required to be reported to the National Practitioner Data Bank; OR have you been notified of any complaints against or reviews of your privileges or affiliations that have not yet been resolved?		
8. During an internship, residency, or fellowship program, were you placed on probation, had your privileges restricted or suspended, terminated from the program or had any other adverse action taken against your participation, even if that action was not required to be reported to the National Practitioner Data Bank?		

TO BE SIGNED BY APPLICANT AND NOTARIZED

I, _____, being first duly sworn upon my oath depose and say: That I am the applicant and the person named in this application and in all materials submitted in support of this application; that all facts therein stated as well as any facts stated on any separate sheet attached hereto, are true, complete, and correct.

Signature of Applicant D.O.

State _____

County _____

Subscribed and sworn to before me this _____ day of _____, 20_____

(SEAL)

Notary Public

My commission expires