



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

9535 E. Doubletree Ranch Road, Scottsdale, AZ 85258

Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

THIS AREA FOR OFFICIAL USE ONLY

Attach a photograph  
for identification purposes  
Approximately  
2" x 2"  
TAKEN WITHIN THE  
PAST SIXTY (60) DAYS  
  
**DO NOT STAPLE PHOTO**  
Transparent tape at edges  
is preferred

**90 DAY LOCUM TENENS REGISTRATION APPLICATION TO PRACTICE MEDICINE**

**Fee: \$300.00**

This application is in accordance with A.R.S. § 32-1823. 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.

If approved, the Locum Tenens registration certificate will be mailed to the sponsoring physician.

**In accordance with A.R.S. § 41-1030 The Board is required to notify you of the following:**

- B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.
- D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.
- E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.
- F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

**SECTION 1: IDENTIFICATION AND CONTACT INFORMATION**

_____		
Last Name	First Name	Middle Name
_____		
Other Names Used (provide copies of marriage license or court records). If this does not apply to you, write N/A.		
_____		
Mailing Address	Cell/Daytime Phone Number	
_____	_____	
City	State	Zip
_____	_____	_____
Gender: Male _____ Female _____		
_____	_____	_____
Email Address	Date of Birth	Social Security Number
_____	_____	_____

**SECTION 2: ALTERNATE CONTACT**

You may authorize someone else to check the status of your application by providing the following information and signing below. If this section is blank, only you, the applicant, will be told the status of this application.

Name of Contact: _____ Phone Number: _____
Name of Company: _____ Email: _____
Address: _____
City, State, Zip: _____
I, _____, give authorization for the above named person to be informed of the status of my application for licensure in Arizona.

**SECTION 3: SPONSORING ARIZONA LICENSED PHYSICIAN**

In addition to providing the information below, the sponsoring physician (M.D. or D.O.) must submit a written request pursuant to A.R.S. § 32-1823(A)(2) which includes the required information as stated in the LT application instructions. To facilitate this request a form has been provided in the application packet (Sponsoring Physician: Written Request for Locum Tenens Registration).

Name of Sponsoring Physician:	
Name of Company/Practice:	
Address:	
City, State, Zip:	Phone Number:
Exact Requested Dates of Locum Tenens (not longer than 90 days):	Start Date: _____ End Date: _____

**SECTION 4: NATIONAL OSTEOPATHIC MEDICAL EXAM**

List the national licensure examinations you passed and dates. If you passed Level 3 of the COMLEX or Part 3 of the USMLE exam in the past seven (7) years, you must provide proof you passed the exam as listed in the instructions (No. 10). If it has been more than seven (7) years since you passed your licensing examinations, you do not need to provide proof. However, you still need to list them in the table below:

Name of Exam / Part or level	Date passed

**SECTION 5: EDUCATION AND TRAINING HISTORY**

Fill in the areas below completely and accurately. Please submit Form No. 1 to the Osteopathic College from which you graduated and Form No. 2 to the accredited program at which you completed your first year of postgraduate training.

	<b>Name of Institution</b>	<b>City/State</b>	<b>Years Attended From/ To</b>
<b>Osteopathic College</b>			
<b>Internship/PGY-1</b>			
<b>Residency</b>			
<b>Residency (if more than one)</b>			
<b>Fellowship</b>			

**SECTION 6: STATE LICENSES**

Fill in the information for each license you hold or have held. If you were previously licensed in Arizona, provide that information also. Please use a separate blank sheet of paper if necessary to provide a complete list. Explain any time you were not in practice. You must request that each state listed (except Arizona) send a verification of license directly to the Arizona Board of Osteopathic Examiners.

<b>Issuing State</b>	<b>License Number</b>	<b>Issue Date: MM/DD/YY</b>	<b>Expiration Date: MM/DD/YY</b>	<b>License Status</b>

**SECTION 7: PRACTICE EXPERIENCE**

Provide a list of all health care facilities, clinics, urgent cares, offices, etc., at which you have practiced medicine, consulted medicine or had staff privileges, whether employed or in private practice. This list must account for all years since initial licensure. This does not include facilities at which you were doing PGT rotations. If more space is needed, please use a separate blank sheet of paper. If this information is in your CV, you may write "see CV" in the table and include your CV with your application instead.

Verification of the last seven (7) years of practice experience is required. Please send Form 3: Practice Experience Verification to the appropriate entities in order to obtain this, and then have the completed form(s) sent directly to the Board in order to maintain the integrity of the verification. We accept verifications by fax, email or mail from the verifying entities only.

<b>Start Date (M/D/YYYY)</b>	<b>End Date (M/D/YYYY)</b>	<b>Name of Health Care Facility or Employer</b>	<b>City/State</b>

**SECTION 8: PROFESSIONAL CONDUCT HISTORY**

Failure to properly answer the questions below may result in Board disciplinary action including revocation of your locum tenens registration.

If you answer "yes" to any of the following questions, please attach an explanation of the situation on a separate blank sheet of paper. As appropriate, attach copies of documents from hospitals, programs, State Boards, courts and law enforcement agencies confirming your explanation.	YES	NO
1. Have you ever been arrested for, charged with or convicted of any felony, or any misdemeanor? You must answer "yes" even if the offense occurred outside of Arizona, the case has not yet been adjudicated, you completed a diversion program, you received a suspended sentence or probation, the convictions were dismissed or set aside, your sentence was commuted, the records were expunged, your civil rights were restored or you received a pardon. <b>A list of reportable misdemeanors is on our website.</b>		
2. 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?		
3. 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?		
4. 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?		
5. Have your hospital privileges or health care program affiliations been 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?		
6. 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?		

**SECTION 9: PROFESSIONAL CONDUCT HISTORY - CONFIDENTIAL QUESTIONNAIRE**

<i>If you answer "yes" to either of the following questions, you must submit a detailed written narrative statement concerning matter(s) including the name of the healthcare providers and treatment centers where you were treated along with the discharge summary of your treatment and progress. If you are currently participating or have participated in a confidential agreement or order in a program for the treatment and rehabilitation of doctors of osteopathic medicine impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with compliance reports from the state monitoring programs.</i>	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 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? You must answer "yes" even if you received a pardon, the convictions were set aside, the records were expunged, your civil rights were restored and whether or not the sentence was imposed or suspended.		

**SECTION 10: OATH and NOTARIZATION TO BE SIGNED BY APPLICANT AND NOTARIZED**

\_\_\_\_\_, D.O.  
Signature of Applicant

\_\_\_\_\_  
Date Signed

State of \_\_\_\_\_ )  
County of \_\_\_\_\_ )

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ before me personally appeared \_\_\_\_\_ (applicant), known to me or whose identity is proved to me by satisfactory evidence to be the person who he/she claims to be and who swore or affirmed before me that the information in this application is true, complete and correct.

Notary Public: \_\_\_\_\_

My commission expires: \_\_\_\_\_

## 90-Day Locum Tenens (LT) Registration Application Checklist

LT Application packets with original notarized signatures must be mailed or delivered to the Board office.  
Scanned or faxed applications are not acceptable.

### BEFORE YOU SEND US YOUR LOCUM TENENS REGISTRATION APPLICATION PACKET, CHECK THAT YOU HAVE COMPLETED THE FOLLOWING:

- 1. A completed and notarized current version of the Board's registration application (August 2014 revision date).
- 2. \$300 application fee. We accept Visa, MasterCard, American Express check or money order. If paying by credit card, please use the credit card payment form included in the application packet. Make your check or money order payable to the Arizona Board of Osteopathic Examiners .
- 3. Written request from the sponsoring M.D. or D.O. licensed in Arizona for whom you are substituting or assisting (see instructions for details).
- 4. Copy of government issued picture ID (e.g., current driver's license or US passport) showing same name as used on application.
- 5. Completed Arizona Statement of Citizenship form and copy of government issued documentation showing citizenship or resident alien status (e.g., current US passport, birth certificate, naturalization certificate, green card, etc.).
- 6. Copy of legal documentation showing change of name, if applicable.
- 7. Explanations and supporting documentation of all "yes" answers to Professional Conduct History. This includes medical malpractice settlements, etc. Use the form "Malpractice Claim/Suit Questionnaire" as a coversheet for each instance of medical malpractice.
- 8. Copy of your diploma or transcript from an approved College of Osteopathic Medicine (COM) showing the date of your graduation. Sent Form No. 1 to your COM for verification.
- 9. Copy of certificate or official letter showing completion of your internship or first year of residency. Sent Form No. 2 to the program where you completed your internship/PGY-1 year for verification.
- 10. Proof that you passed the national osteopathic medical examination(s).
- 11. Sent Form No. 3 to all facilities where you practiced medicine in the last seven (7) years for verification.
- 12. Requested verification of licensure and disciplinary history from each state in which you are or have been licensed be sent to the Arizona Board of Osteopathic Examiners.

Do not include this checklist with your application. Its purpose is to help you complete the paperwork associated with licensure and submit a satisfactory application, thereby preventing unnecessary delays.

Please call or email with any questions  
480-657-7703



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**Form No. 1: PROFESSIONAL EDUCATION VERIFICATION**

In applying for a locum tenens registration in Arizona, the Arizona Board of Osteopathic Examiners requires this form be completed by the **Dean or the Registrar** of the osteopathic medical school from which you graduated. This is authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY to the ARIZONA BOARD OF OSTEOPATHIC EXAMINERS, 9535 East Doubletree Ranch Road, Scottsdale, Arizona 85258.**

Applicant Name: \_\_\_\_\_, D.O. Last 4 digits of SSN: \_\_\_\_\_

Signature \_\_\_\_\_ Date (Month/Day/Year)\_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE OSTEOPATHIC MEDICAL SCHOOL**

This certifies that \_\_\_\_\_, D.O.  
(Name of Applicant)

was enrolled in: \_\_\_\_\_  
(Name of Osteopathic College of Medicine)

\_\_\_\_\_  
(Location – City/State)

The undersigned further certifies that the records of this institution show that the applicant was granted an Osteopathic Medical Degree by the above named COM on: \_\_\_\_\_ Date (Month/Day/Year)

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name Typed or Printed: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Contact person, if different than above: \_\_\_\_\_

Email: \_\_\_\_\_

**TO MAINTAIN INTEGRITY OF THE VERIFICATION, SEND ORIGINAL DIRECTLY TO THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS**



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Form No. 2: POSTGRADUATE TRAINING VERIFICATION

FOR APPLICANT: Make as many copies as needed. Mail or fax this form to the program director of each postgraduate training (PGT) program in which you participated regardless of completion. This completed form is a requirement of locum tenens registration in Arizona. Your signature below is authorization to release any information about you in your PGT program's files of record, favorable or otherwise DIRECTLY to the Arizona Board of Osteopathic Examiners in Medicine and Surgery.

Applicant Name: \_\_\_\_\_, D.O.

Signature \_\_\_\_\_ Date (Month/Day/Year) \_\_\_\_\_

THIS SECTION TO BE COMPLETED BY PROGRAM DIRECTOR

FOR PGT PROGRAM DIRECTOR: The above named individual has applied for a locum tenens registration in Arizona and has stated that he/she has participated in a PGT program at your facility. He/she is required to submit this form to you for completion. Therefore, please complete this form and return it to our office at the address above.

1. Important - Program Participation: Please report internships, residencies and fellowships separately. Please report incomplete postgraduate years (PGY) separately from those successfully completed. If the postgraduate year is currently in progress, report the expected completion date in the "To" field.

PG Year(s): \_\_\_\_\_ DEPARTMENT/SPECIALTY: \_\_\_\_\_
From: \_\_\_\_\_ To: \_\_\_\_\_
Successfully completed? Yes No In Progress

PG Year(s): \_\_\_\_\_ DEPARTMENT/SPECIALTY: \_\_\_\_\_
From: \_\_\_\_\_ To: \_\_\_\_\_
Successfully completed? Yes No In Progress

PG Year(s): \_\_\_\_\_ DEPARTMENT/SPECIALTY: \_\_\_\_\_
From: \_\_\_\_\_ To: \_\_\_\_\_
Successfully completed? Yes No In Progress

2. The following questions apply to the PGT years stated above. Please check the appropriate response.

- a. This program was approved for postgraduate training during this individual's attendance by:
b. Did this individual ever take a leave of absence or deferment/break from his/her training?
c. Was this individual disciplined and/or placed under investigation or on probation?
d. Did this individual participate in a confidential or public diversion program for substance abuse monitoring?

Please explain below any "Yes" response(s) to the questions above. Use a separate blank sheet of paper if more room is necessary.

3. COMMENTS: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name Typed or Printed: \_\_\_\_\_ Title: \_\_\_\_\_

Full name of Program or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Contact person, if different from above: \_\_\_\_\_ Email: \_\_\_\_\_



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**Form No. 3: PRACTICE EXPERIENCE VERIFICATION**

In applying for a locum tenens registration in Arizona, the Arizona Board of Osteopathic Examiners requires this form be completed by the **Medical Employer/Director** where I have practiced medicine for evaluation of my professional record and mental and physical capabilities during the seven (7) years preceding my application. This is authorization to release any information in your files of record **DIRECTLY** to the Arizona Board of Osteopathic Examiners, 9535 East Doubletree Ranch Road, Scottsdale, AZ 85258.

Applicant Name: \_\_\_\_\_, D.O.

Signature \_\_\_\_\_ Date (Month/Day/Year) \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY FACILITY OFFICIAL**

1. This is to certify that \_\_\_\_\_, D.O.,

held/holds the following position: \_\_\_\_\_

Dates: From: \_\_\_\_\_ To: \_\_\_\_\_  
Month/Day/Year Month/Day/Year

**Circle the correct response to the questions below: ("Yes" responses require written explanation.)**

2. Has this individual participated in a confidential or public diversion program for substance abuse monitoring? **Yes** **No**

3. Was this individual disciplined and/or placed under investigation or on probation? **Yes** **No**

*Please explain below any "Yes" response(s) to the two questions above.  
Use a separate blank sheet of paper if more room is necessary.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Practice/Facility: \_\_\_\_\_ Phone No: \_\_\_\_\_

Address: \_\_\_\_\_ Fax No.: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Official (printed): \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO MAINTAIN INTEGRITY OF THE VERIFICATION, SEND ORIGINAL DIRECTLY TO THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS**

**Arizona Board of Osteopathic Examiners LT Registration Application**  
**MALPRACTICE CLAIM/SUIT QUESTIONNAIRE**

Complete the information below for each instance of any award, settlement or payment of any kind either 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 Practitioners Data Bank, OR if you have been notified that any such suit or claim is pending. Duplicate this form as necessary.

1. Applicant's name: \_\_\_\_\_

2. Name of patient: \_\_\_\_\_  
Last name                      First name                      Middle name/initial

3. Date of occurrence \_\_\_\_\_

4. Location of occurrence: \_\_\_\_\_  
Name of hospital/office/clinic                      City / State

5. Current status of suit/claim:     Pending                       Settled

If settled, was it settled:     in court     out of court    Date of settlement:    \_\_\_\_ / \_\_\_\_ / \_\_\_\_

6. Total amount of settlement/award \_\_\_\_\_ Amount attributable to you \_\_\_\_\_

7. Name of your insurance company: \_\_\_\_\_

8. Has this case been investigated or reviewed by any State Board?     No     Yes     Pending

If Yes or Pending, name of Board: \_\_\_\_\_

9. In your own words, **briefly describe the claim/suit**, and your involvement. You may use additional sheets if necessary. Attaching the NPDB description is not an acceptable response.

10. **Attach the following documents to this form.** Your application will not be decided upon until all of the following documents have been received:

- a. plaintiff's complaint or claim to insurer;
- b. settlement agreement, court order, or dismissal letter (if case has concluded) and
- c. Board resolution after investigation of case (if case has concluded).

\_\_\_\_\_  
Signature of applicant

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

**ARIZONA STATEMENT OF CITIZENSHIP  
AND ALIEN STATUS FOR STATE PUBLIC BENEFITS**

**Professional License and Permit**

**Arizona Board of Osteopathic Examiners in Medicine & Surgery**

Title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the "Act"), 8 U.S.C. § 1621, provides that, with certain exceptions, only United States citizens, United States non-citizen nationals, non-exempt "qualified aliens" (and sometimes only particular categories of qualified aliens), nonimmigrants, and certain aliens paroled into the United States are eligible to receive state or local public benefits. With certain exceptions, a professional license and commercial license issued by a State agency is a State public benefit.

Arizona Revised Statutes § 41-1080 requires, in general, that a person applying for a license must submit documentation to the license agency that satisfactorily demonstrates the applicant's presence in the United States is authorized under federal law.

**Directions: All applicants must complete Sections I, II, and IV. Applicants who are not U.S. citizens or nationals must also complete Section III.**

**Submit this completed form and a copy of one or more document(s) from the attached "Evidence of U.S. Citizenship, U.S. National Status or Alien Status" with your application for license or renewal. If the document you submit does not contain a photograph, you must also provide a government issued document that contains your photograph. You must submit supporting legal documentation (i.e. marriage certificate) if the name on your evidence is not the same as your current legal name.**

**SECTION I – APPLICANT INFORMATION**

APPLICANT'S NAME (Print or type) \_\_\_\_\_

TYPE OF APPLICATION (Check one)       INITIAL APPLICATION       RENEWAL

TYPE OF LICENSE/PERMIT (Check one)       DO       PGT       Locum Tenens

**SECTION II – CITIZENSHIP OR NATIONAL STATUS DECLARATION**

Are you a citizen or national of the United States?       Yes       No

If **Yes**, indicate place of birth:

City \_\_\_\_\_ State (or equivalent) \_\_\_\_\_ Country or Territory \_\_\_\_\_

If you answered **Yes**,    1) Attach a legible copy of one or more document(s) from the attached "Evidence of U.S. Citizenship, U.S. National Status or Alien Status" page.  
Name of document \_\_\_\_\_

2) Go to Section IV.

If you answered **No**, you must complete Section III and IV.

**SECTION III – ALIEN STATUS DECLARATION**

To be completed by applicants who are not citizens or nationals of the United States. Please indicate alien status by checking the appropriate box. Attach a legible copy of one or more document(s) from the attached "Evidence of U.S. Citizenship, U.S. National Status or Alien Status". Name of document provided \_\_\_\_\_.

Qualified Alien Status (8 U.S.C. §§ 1621(a)(1),-1641(b) and (c))

- 1. An alien lawfully admitted for permanent residence under the Immigration and Nationality Act (INA)
- 2. An alien who is granted asylum under Section 208 of the INA.
- 3. A refugee admitted to the United States under Section 207 of the INA.
- 4. An alien paroled into the United States for at least one year under Section 212(d)(5) of the INA.
- 5. An alien whose deportation is being withheld under Section 243(h) of the INA.
- 6. An alien granted conditional entry under Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
- 7. An alien who is a Cuban/Haitian entrant.
- 8. An alien who has or whose child or child's parent is a "battered alien" or an alien subject to extreme cruelty in the United States.

Nonimmigrant Status (8 U.S.C. § 1621(a)(2))

- 9. A nonimmigrant under the Immigration and Nationality Act [8 U.S.C § 1101 et seq.] Nonimmigrants are persons who have temporary status for a specific purpose. See 8 U.S.C § 1101(a)(15).

Alien Paroled into the United States For Less Than One Year (8 U.S.C. § 1621(a)(3))

- 10. An alien paroled into the United States for less than one year under Section 212(d)(5) of the INA

Other Persons (8 U.S.C § 1621(c)(2)(A) and (C))

- 11. A nonimmigrant whose visa for entry is related to employment in the United States or
- 12. A citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99-239 or 99-658 (or a successor provision) is in effect (Freely Associated States include the Republic of the Marshall Islands, Republic of Palau and the Federate States of Micronesia, 48 U.S.C. § 1901 *et seq.*);
- 13. A foreign national not physically present in the United States.

Otherwise Lawfully Present

- 14. A person not described in categories 1-13 who is otherwise lawfully present in the United States. **PLEASE NOTE: The federal Personal Responsibility and Work Opportunity Reconciliation Act may make persons who fall into this category ineligible for licensure. See 8 U.S.C. § 1621(a).**

<b>SECTION IV - DECLARATION</b>
---------------------------------

**All applicants must complete this section.**

I declare under penalty of perjury under the laws of the state of Arizona that the answers and evidence I have given are true and correct to the best of my knowledge.

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
TODAY'S DATE

# EVIDENCE OF U.S. CITIZENSHIP, U.S. NATIONAL STATUS OR ALIEN STATUS

**You must submit supporting legal documentation (i.e. marriage certificate) if the name on your evidence is not the same as your current legal name.**

**Evidence showing authorized presence in the United State includes the following:**

1. An Arizona driver license issued after 1996 or an Arizona non-operating identification license.
2. A driver license issued by a state that verifies lawful presence in the United States.
3. A birth certificate or delayed birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa or the Northern Mariana Islands (on or after November 4, 1986, Northern Mariana Islands local time)
4. A United States certificate of birth abroad.
5. A United States passport. \*\*\*Passport must be signed\*\*\*
6. A foreign passport with a United States visa.
7. An I-94 form with a photograph.
8. A United States citizenship and immigration services employment authorization document or refugee travel document.
9. A United States certificate of naturalization.
10. A United States certificate of citizenship.
11. A tribal certificate of Indian blood.
12. A tribal or Bureau of Indian Affairs affidavit of birth.
13. Any other license that is issued by the federal government, any other state government, an agency of this state or a political subdivision of this state that requires proof of citizenship or lawful alien status before issuing the license.



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**Sponsoring Physician: Written Request for Locum Tenens Registration**

To be completed by the Arizona licensed doctor of osteopathic medicine (D.O.) or doctor of medicine (M.D.) requesting locum tenens registration of the applicant in accordance with A.R.S. § 32-1823.

1. Name of Locum Tenens Applicant: \_\_\_\_\_, D.O.

2. Applicant will be providing locum tenens medical services to (check one):

**SUBSTITUTE FOR** the sponsoring physician

**TEMPORARILY ASSIST** the sponsoring physician

3. Exact Start Date for which Locum Tenens is requested: \_\_\_\_\_ (month, day, year)

Granted Locum Tenens registration is valid for ninety (90) days and may be extended once for an additional ninety (90) days upon written request from the sponsoring physician who originally initiated the request for this registration. The written request must state the reason for the extension. Submit the appropriate fees and other documents requested by the Executive Director.

4. Name of Sponsoring Physician (print): \_\_\_\_\_ Arizona License No.: \_\_\_\_\_

5. Sponsoring Physician Contact Information:

Name of Practice	
Address	
Address	
City, State and Zip	
Phone Number	
Fax Number	

6. \_\_\_\_\_ D.O. M.D. Date: \_\_\_\_\_  
Signature of Arizona Licensed Sponsoring Physician (circle one)



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**CREDIT CARD PAYMENT AUTHORIZATION FOR  
OSTEOPATHIC LOCUM TENENS REGISTRATION APPLICATION FEE**

Name of Applicant: \_\_\_\_\_, D.O.

Please complete and mail with your application if paying by credit card.

**Amount: \$300.00**

Type of Card:  Visa  MasterCard  American Express

Visa or MasterCard #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

OR

American Express #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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 (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*

## Locum Tenens Registration Application Processing Overview

### ***YOU HAVE SUBMITTED YOUR APPLICATION, WHAT HAPPENS NEXT?***

**EMAIL ACKNOWLEDGEMENT:** When Board staff has received your application packet, you will be sent an email acknowledging receipt. If you do not provide an email address, no acknowledgement will be sent. This acknowledgement does not mean that all required documents have been received.

**ADMINISTRATIVELY COMPLETE/DEFICIENCY LETTER:** Within thirty (30) days after receipt of the application, staff will mail a letter to you listing the missing or incomplete information needed to complete your application.

If all the documents on the checklist have been received, you will not receive this letter.

**ADMINISTRATIVELY COMPLETE:** After everything on the checklist has been received, the Board staff will independently obtain the following:

1. National Practitioner Data Bank report
2. Federation of State Medical Board's Practitioner Profile

At this point your application is administratively complete and moves to substantive review.

**SUBSTANTIVE REVIEW:** This stage of the application process is the evaluation of all answers, documents, and verifications collected and the decision whether they demonstrate you are qualified for the locum tenens registration. You may be required to appear before the Board at a regularly scheduled Board meeting for a decision on your application.

**ISSUANCE OF LOCUM TENENS REGISTRATION:** If, at the conclusion of the substantive review, your application is approved, you will receive a letter by email and regular mail letting you know your Locum Tenens Registration has been issued. Your registration number, effective date, and expiration date are also provided. Included with the letter is a copy of the issuance letter and registration certificate sent to your sponsoring physician.

As of the effective date of registration you may assist or substitute for the sponsoring physician. A Locum Tenens Registration does not authorize you to practice medicine independently in Arizona. If you want to practice in Arizona at a facility or location other than your sponsoring physician's practice location(s), you will need to obtain full licensure.

If your sponsoring physician wants you to continue assisting or substituting for him/her after the expiration date, the sponsoring physician must send a written request stating the reason for the extension. Another \$300 fee must be paid in order to extend the registration for another 90 days. This request may be sent to the Board office by fax, email, or regular mail.

Arizona Revised Statutes and Rules for osteopathic licensure can be found on our website at [www.azdo.gov](http://www.azdo.gov) > Statute and Rules. As a Locum Tenens registered physician, you will be subject to all state and local laws and regulations pertaining to public health and subject to all the same duties and obligations and authorized to exercise all the same rights and privileges possessed by physicians and surgeons of other complete schools of medicine in the practice of their profession per A.R.S. § 32-1852.