

ARIZONA MEDICAL BOARD

POSTGRADUATE TRAINING PERMIT REGISTRATION

(Internship-Residency-Fellowship)

The Board shall grant a one year renewable training permit to a person participating in a teaching hospital's accredited internship, residency or clinical fellowship training program to allow that person to function only in the supervised setting of that program. If a person who is participating in a teaching hospital's accredited internship, residency or clinical fellowship program must repeat or make up time in the program due to resident progression or other issues, the Board may grant that person a training permit if requested to do so by the program's director of medical education or a person who holds an equivalent position. The individual must register with the Board for each year of training and pay the statutory nonrefundable **\$50.00** registration fee.

The following information must be completed by the applicant and the licensed hospital which sponsors the accredited training program. This form also applies to applicants applying for a short-term training permit of four months or less. Please submit the registration to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, AZ 85258 at least **thirty days prior** to the initiation of the training.

(Check this box if this is a renewal for a current Postgraduate Training Permit)

Permit # R _____ Expiration Date _____

1. Applicant Name: _____
(Last) (First) (Middle)

2. Current home address: _____
(Number and Street) (City) (State) (Zip)

3. Mobile Phone Number: _____ Home Phone Number: _____

4. E-Mail address: _____

5. Date of Birth: _____
(Month, Day and Year) (City, State and Country of Birth)

6. Social Security Number: _____

PROGRAM TO COMPLETE BELOW:

Type of Program: Internship Residency Fellowship

Name of Facility: _____
(Arizona ACGME Approved Hospital or University Name)

Specialty Field: _____
(i.e. Internal Medicine, Gastroenterology, Psychiatry, Family Medicine, etc....)

Permit Dates requested from: _____ to _____ (not to exceed one year)
(mm/dd/yy) (mm/dd/yy)

I hereby certify I am authorized to request a postgraduate training permit for the above named facility.

Signature _____ Title _____

Name Printed: _____

Date: _____ Phone Number: _____

Arizona Medical Board: Permit Issued Date _____ Permit Number _____



ARIZONA MEDICAL BOARD

**PAYMENT CARD AUTHORIZATION
POSTGRADUATE TRAINING PERMIT FEE**

Payment for: _____, M.D.

POSTGRADUATE TRAINING PERMIT FEE \$50

Type of Card: Visa MasterCard American Express

Card #: - - -

Expiration Date: - (MM-YY)

Name as Shown on Payment Card: _____

Billing Address:

(Required)

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number of Cardholder: _____

(Required)

Mailing Address (If different from billing address):

Street Address: _____

City: _____ State: _____ Zip: _____

Signature of Cardholder: _____ Date: _____

Please complete and return this form the *application* if paying by credit card.

This form and the application may be faxed to: 480-551-2704

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

OR

You may mail the form and all necessary documents to: Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258