License Status Change Request Form

ARIZONA MEDICAL BOARD
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 - Toll Free: 877-255-2212 - Fax: 480-551-2704
Website: www.azmd.gov - E-Mail: questions@azmd.gov

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First Name: _____ **Last Name:** _____

License Number: _____

Practice Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Mailing Address: _____

Required City: _____ State: _____ Zip Code: _____

Please check if your home and mailing address are the same: ☐ Yes ☐ No

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ eMail: _____

☐ **I request *INACTIVATION* of my medical license.** I am not presently under investigation by the Board, the Board has not commenced disciplinary proceedings against me, and ***I am totally retired from the practice of medicine in this state or any state, territory, or district of the United States or foreign country***. Inactive status means you may not practice medicine. I understand that once inactive status is granted, the Board will waive the renewal fees and requirements for CME. I understand that I may not engage in the practice of medicine in Arizona or in any state, territory, or district, of the United States or foreign country, hold registration with the Drug Enforcement Administration, or write prescriptions as long as my license is classified as inactive. I further understand that if I request reactivation of my license, the Board may require me to pass the SPEX and any combination of physical, psychiatric, or psychological examinations or interviews it deems necessary to determine my ability to safely engage in the practice of medicine. A.R.S. §32-1431.

- *Please be aware that upon approval of your request you will not be able to practice medicine until you convert your inactive license to an active license pursuant to A.R.S. §32-1431(D) or apply for pro bono registration pursuant to A.R.S. § 32-1428. Please be further aware that should you seek to obtain a license to practice medicine in any state, territory, or district of the United States or foreign country you must notify the Arizona Medical Board of such request.*

☐ **I request *CANCELLATION* of my medical license**. I am not presently under investigation by the Board, the Board has not commenced disciplinary proceedings against me, and I am no longer practicing medicine in Arizona.

Signature: _____ Date: _____

I hereby attest that I meet the requirements to change the status of my license to practice in Arizona.