



ARIZONA MEDICAL BOARD
 1740 W. Adams St. Suite. 4000, Phoenix, AZ 85007-2664
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, 1740 W. Adams Street, Suite. 4000, Phoenix, AZ 85007 at least **thirty (30) days prior** to the initiation of the training.

Check this box if this is a renewal for a current Post Graduate Training Permit.

Permit # R Expiration Date:

First Name: Initial: Last Name:

Current Home Address: City: State: Zip:

Mobile Phone: Home Phone: Email:

Date of Birth (Month, Day, Year): Birth City: State: County:

Social Security Number:

Please indicate if you would like to designate/authorize ONE other individual beside yourself to receive status updates on your application

Name: Phone# Email:

Citizenship Statement

This form is to be completed by the applicant and is to be submitted for every application, permit or registration that is offered by the Arizona Medical Board, with the exception of the renewal of license if citizenship has previously been established with the Board.

Evidence List

Provide proof of lawful presence in the United States in accordance with A.R.S. § 41-1080 (See [Evidence List- as referenced for miscellaneous license application types](#) at www.AZMD.GOV/Physician Center/New Arizona License.).

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 (m/dd/yr) To (m/dd/yy): *Not to exceed one year*

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

Signature: Title:

Name (Printed): Phone Number:

Date:

Arizona Medical Board: Permit Issued Date: _____ Permit Number: _____

**PAYMENT CARD AUTHORIZATION
POSTGRADUATE TRAINING PERMIT FEE**

Payment for: First Name Last Name

POSTGRADUATE TRAINING PERMIT FEE \$50.00

Type of Card: Visa Mastercard Amex

Card Number: **Expiration Date**

Name as Shown on Payment Card:

Billing Address of Cardholder: **City:** **State:** **Zip:**
(Required)

Office Phone:

Mailing Address of Cardholder: **City:** **State:** **Zip:**
(If different from billing address)

Cardholder Signature: **Date:**
(Required)

The Arizona Medical Board will only accept credit card payment via mail (USPS, FedEx, UPS, or any other mail carrier). Any credit card information received via any other method will not be processed and will be destroyed.

Please complete and return this form *with your license application and all necessary documents.* Return the application and payment form (credit card form, check or money order) to the address listed below.

Mail to: Arizona Medical Board
1740 W. Adams St. Ste. 4000
Phoenix, AZ 85007-2664

For receipt, please include an e-mail address for submission: **E-Mail Address:**