ARIZONA MEDICAL BOARD
CLINICAL INSTRUCTOR VERIFICATION FORM

AUTHORIZATION: The Arizona Medical Board requires all applicants for licensure to obtain verification of all hospitals where they have been employed as a clinical instructor. This form must be completed by the **Program Director**. This is authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board. Authorization may be sent via mail or fax to 1740 W. Adams St. Ste. 4000, Phoenix, AZ 85007 or (480) 551-2704.

First Name: ______ **Last Name:** ______

Signature: ______ **Date:** ______

This is to certify that the applicant listed above was a full time (rank, i.e. assistant professor) ______

in the (type of program) ______ at (name of program) ______

Located in: City: ______ State: ______ in the field of: ______

From: ______ To: ______

1. The said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada. ☐ Yes ☐ No

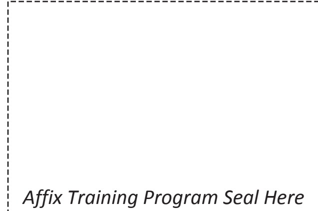
2. Have the applicant's hospital or teaching duties ever been restricted or limited? ☐ Yes ☐ No *If **YES**, please provide a written explanation.*

3. Was the applicant granted full clinical privileges at your institution? ☐ Yes ☐ No *If **NO**, please provide a written explanation.*

4. Was there any reason not to continue the applicant as an instructor? ☐ Yes ☐ No *If **YES**, please provide a written explanation.*

5. Was the applicant's performance as an instructor consistently rated satisfactory and/or above? ☐ Yes ☐ No *If **NO**, please provide a written explanation and a copy of the evaluation(s).*

Written Explanation(s): ______


Affix Training Program Seal Here

Name/Title: ______

Address: ______ City: ______ State: ______ Zip: ______

Phone: ______ Fax: ______ Signature: ______