

*******NOTICE*******

This Is A Requirement For Licensure

The Arkansas Medical Practices Acts and Regulations must be read in its entirety prior to submitting an application for medical license to the Arkansas State Medical Board. You must complete the Rules and Regulation Affidavit located in this packet.

The Medical Practices Act can be viewed at www.armedicalboard.org. Go to the Help Desk and then Downloads.

Attention International Medical Graduate Physician Applicants

Effective June 1, 2010

Regulation 3 of the Arkansas State Medical Board Rules and Regulations has amended the licensing requirements for international medical graduates.

REGULATION NO. 3

UNRESTRICTED LICENSURE FOR GRADUATES OF FOREIGN MEDICAL SCHOOLS

Unrestricted license may now be applied for by graduates of foreign medical schools provided they can comply with the following requirements and meet the approval of the Board of Medical Examiners;

1. Be twenty-one years of age.
2. Be of good moral character.
3. Demonstrated in personal interview the ability to read, write, and speak English fluently; and also demonstrate adequate training and ability sufficient to permit the practice of medicine in accordance with accepted medical practice in the State of Arkansas.
4. Present documented evidence that he or she served three years as an intern or resident in an accredited postgraduate medical education program in the United States; or, completed one year as an intern or resident in an accredited post-graduate medical program in the United States and be currently enrolled in an accredited post-graduate medical program in Arkansas. The Applicant should further provide a Letter of Recommendation from the Intern or Residency Director, outlining the Applicant Physician's competence in the practice of medicine and his ability to appropriately interact with patients and other medical staff.
5. Provide indisputable identification.
6. Present a Standard ECFMG (Educational Commission for Foreign Medical Graduates Exam) Certificate.
7. A. Present proof of successful completion of Steps 1, 2 and 3 of the USMLE (United States Medical Licensing Exam) within 7 years from the time the applicant passes or successfully completes Step 1 or Step 2, whichever is completed first.
B. The applicant must successfully complete each step in no more than 3 attempts per step.

A waiver may be granted by the Board, if requested by the applicant, from the "3 attempt per step limit," for Step 1 and/or Step 2. The waiver will be granted if the Board finds that the applicant can show documentation and proof that he/she suffered from a significant health condition or personal problem, and that by its severity would necessarily cause delay to the applicant's medical education and successful completion of the step testing. The waiver will not exceed 4 attempts per step.

A waiver may also be granted to the "3 attempt per step limit" on step 3 not to exceed 4 attempts if:

- 1) The applicant has completed one year of approved graduate medical education after the 3rd failed attempt and before the fourth and final attempt at step 3; or
 - 2) The applicant can show proof that he/she is certified in a Specialty Board by the American Board of Medical Specialties.
- C. The seven year period to pass all steps may be extended, not to exceed 10 years, by the Board, if the applicant:
- 1) Is certified in a Specialty Board by the American Board of Medical Specialties; or
 - 2) Can retake the appropriate step to bring the successful completion of the 3 Steps within the 7 year time period.
- D. No further waivers will be granted except as set forth in this Regulation.

History: Amended June 17, 1982; June 16, 1983; April 13, 1984; September 7, 1995; August 4, 2005; June 5, 2008; April 8, 2010 (changes effective 6/1/2010)

Attention International Medical Graduate Physician Applicants

Effective July 1, 2005

Act 498 of 2005 has changed the licensing requirements for international medical graduates.

As of July 1, 2005 all medical license applicants who are internationally trained must have completed at least three (3) years of US postgraduate training, *or* have completed at least one (1) year of US postgraduate training and be currently enrolled in an accredited postgraduate training program in Arkansas.

Arkansas code 17-95-403(b) states: *He or she must also have:*

- (1) Served three (3) years as an intern or resident in an accredited postgraduate medical education program in the United States; or*
- (2) Completed one (1) year as an intern or resident in an accredited postgraduate medical education program in the United States and be currently enrolled in an accredited postgraduate medical program in Arkansas.*

Any application for medical license of an international medical graduate received on or after July 1, 2005 must meet this requirement.

Attention Prospective Applicants and Current Licensees

Effective July 1, 2005

Act 1249 of 2005 has changed the new/renewal licensing requirements for all applicants/licensees.

As of July 1, 2005 every person applying for a license/renewal – M.D., D.O., LRCP, OT, OT-A and PA – must complete a criminal background check and/or authorize the Arkansas State Medical Board to conduct such check.

Arkansas code 17-95-306 states:

(a)(1) Beginning July 1, 2005, every person applying for a license or renewal of a license issued by the Arkansas State Medical Board shall provide written authorization to the board to allow the Arkansas State Police to release the results of a state and federal criminal history background check report to the board.

(2) The applicant shall be responsible for payment of the fees associated with the background checks.

Any application for license/renewal received on or after July 1, 2005 must meet this requirement.

Note: The Arkansas State Medical Board criminal background check packet will be mailed to the applicant upon receipt of an application for license. The Federal level portion of this check can take six weeks or more to process. An applicant will not be considered for full licensure until this response is received.



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

Dear Doctor:

Enclosed is an application for licensure in the State of Arkansas. We welcome you and are glad you have chosen to come to our state.

Collecting information for your license can be a tedious task. It is important for you to understand that this process takes a minimum of six weeks for completion and can last up to four to six months. This depends totally on your work history and the timely responses we receive from our investigation and your verification requests. For your own security, it is important that you **DO NOT** make final commitments, purchase a home or relocate your family, before your license has been granted. A Temporary Permit prior to the Board Meeting does **NOT** mean automatic licensure. The licensure process is not complete until the Board meets and your license has officially been approved.

To insure efficiency, please type, or print legibly (black or blue ink **ONLY**) on your application and read the instructions for each question carefully before answering. Make sure all required notary seals are affixed on the application and all documentation has been certified. **ANSWER ALL QUESTIONS.** If the question does not pertain to you, write, "Not Applicable, N/A or None". Your application or verifications will be returned to you if it is not complete or if pictures are not attached where required. The process will cease until the application has been completed correctly and returned to this office. This will only lengthen your waiting time. Faxed copies are **NOT** accepted for documentation or verification purposes. Stamped signatures are not accepted on any documentation. The Arkansas State Medical Board requires that the applicant sign each verification form. (Copied signature on multiple, like forms is ok.) Any verification received that has "see release", or is signed by another individual on behalf of the applicant will not be accepted and the verification will have to be redone.

Enclosed you will find a listing of the web addresses for the AMA, AOA, NBME, FSMB, NBOME, ECFMG and National Personnel Records Center, to contact them online for the applicable requests. All physicians who are applying must complete and transmit the "Request for Physician Profile" to the AMA. If you are a member of the AMA there is no fee, however, nonmembers are required to pay the AMA.

Osteopathic physicians must transmit Physician Profile request to the AOA (in lieu of the AMA Profile) at the web address provided.

You will need to submit a copy of your current CV. This must be received with your application and will not be accepted in lieu of a completed application.

Upon receipt of your completed application, it will be entered in the system and then routed to a licensure coordinator, who will review to determine the status. You will receive a letter of acknowledgment within 7-10 business days after your coordinator receives your application. The letter will advise you of anything needed to complete your file at that point. Please keep in mind that sometimes a received verification may need more information from the verifying source.

Act 1249 of 2005 has authorized the Arkansas State Medical Board to conduct criminal background checks (both state and federal) on applicants for licensure. Upon receipt in this office of your completed application and fee, instructions will be forwarded to you on the process for obtaining the background check. The Federal level portion of this check can take six weeks or more to process. An applicant will not be considered for full licensure until this response is received.

Unnecessary phone calls to check on the status of your application will only delay the processing time. Applications are processed in the order in which they are received in our office. **THE BOARD DOES NOT ACCELERATE ONE APPLICANT OVER ANOTHER.**

If you have history of malpractice, disciplinary action, impairment history, etc., additional time will be required for our investigation.

Applications that are not complete after one year will be placed in the Inactive File and will be withdrawn from our system. No refunds will be given on applications over one year old; applications which are withdrawn after completion, and while waiting on Board appearance date; or those applicants who make an appearance and then withdraw. Applicants who withdraw their application may reapply at a later date but must complete a new application and submit an additional \$500 (\$400 application fee and \$100 processing fee). A partial refund of \$100 may be requested in writing if the application is withdrawn prior to completion, prior to Board appearance or expiration of the six-month period stated above.

For your application to be placed on the Board Meeting agenda it must be complete and all required documentation, including staff investigations, must be in this office by the deadline date. There are **NO EXCEPTIONS** to this policy. Faxed copies **ARE NOT** accepted for documentation or verification purposes.

Before being granted a license, the following applicants will be required to make a personal appearance before the Board:

- a) International Medical School Graduates
- b) Applicants who have disciplinary actions, and/or impairment history
- c) Applicants with malpractice history

If you are required to make a Board Appearance, you will be notified of the time and date of your appearance prior to the next scheduled Board Meeting. Licenses are granted only at regularly scheduled Board Meetings. The Board may reschedule meetings at their discretion. Meeting dates and completed application deadlines for the year are as follows:

<u>File Completed Deadline Date</u>	<u>Board Meeting Approval Date</u>
January 5, 2010	February 4 – 5, 2010
March 9, 2010	April 8 – 9, 2010
May 4, 2010	June 3 – 4, 2010
July 6, 2010	August 5 – 6, 2010
September 8, 2010	October 7 – 8, 2010
November 3, 2010	December 2 – 3, 2010

Upon approval, Temporary Permits can be issued after every detail of the application process has been completed and is ready for Board approval. Temporary permits must be requested in writing and the required fee of \$50.00 must be enclosed. No permit can be issued without payment or written request. *Please note that temporary permits expire on the last day of each Board Meeting and renewal is your responsibility by submitting a request and additional \$50 fee.* Again, remember, a Temporary Permit does NOT mean that you will receive a permanent license. That is a Board decision.

Please note that the Arkansas State Medical Board does NOT accept the Federation Credentials Verification Service (FCVS) in lieu of the credentialing process.



Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, AR 72202
Phone: (501) 296-1802
Fax: (501) 296-1972
www.armedicalboard.org

Memo

To: Licensing Applicant
From: Arkansas State Medical Board
Subject: Mailing Recommendations

Based on our historical experience with the U.S. Postal Service, **we strongly recommend you utilize FedEx, UPS, or DHL** for mailing any documentation to us, which is required in the licensing process.

We further recommend you contact all entities you will be sending verification forms to (which are returned directly to the Arkansas State Medical Board), and **request they also utilize FedEx, UPS, or DHL**, offering to enclose payment for that type of mailing.

We believe the flow of paperwork needed will be a much smoother and less stressful experience for you if you encompass these recommendations for your paperwork.

If you do prefer to use regular mail, please take this as forewarning that in our experience we do not always receive mail through the U.S. Postal Service in a timely manner, and **we cannot be responsible for their delivery time frame.** Utilizing regular mail could delay the processing time of your application.

Thank you.



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Authorization to Release Pending Licensure Application File Information

So the licensing process might be made easier for both you and the Board, we do limit our communication about your file to you and one other person of your choice. We have found that in the past, phone calls providing duplicate information have only slowed the process, which will delay the licensure process for you. Provide the Board in writing with the name of the person, other than yourself, that will be working with you to complete your file.

Your licensing coordinator will be working with over one hundred (100) other applicants at the time she is working with you. To streamline this process, your coordinator will communicate with you and one other person of your choice regarding your file. It has been proven that communicating with multiple people and providing duplicate information slows the process and the period in which you will receive your license or temporary permit. Until written notification of the other contact, has been received, the coordinator will communicate only with you.

I authorize the Arkansas State Medical Board to release any and all information regarding the status of my licensure file to the person listed below:

(Print full name of Representative)

(Email address of Representative)

(Phone number of Representative)

(Print full name of Applicant)

(Signature of Applicant)

(Date Signed)



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Little Rock, AR 72202
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Fax: 501.296.1972
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Important Communication Tools for Physician License Applicants

Arkansas State Medical Board Website:

www.armedicalboard.org

- Medical Practices Act can be downloaded at anytime
- Updates: Changes in laws or regulations
- Applications and verification forms can be viewed or downloaded
- License verifications
- Board meeting dates

Contact at the Arkansas State Medical Board:

- Licensing Coordinators (depending on your last name):
 - Pat Fisher: A – H
 - 501.296.1956
 - Email: pkf@armedicalboard.org
 - Laurel Mills: I – Q
 - 501.296.1804
 - Email: ljm@armedicalboard.org
 - Kay Zuber: R – Z
 - 501.296.1950
 - Email: kez@armedicalboard.org
- Fax: 501.296.1972
- Hours: 8:00 am – 5:00 pm weekdays

Current Fees:

- Full License - \$500.00
- Temporary License - \$50.00 (\$550.00 total when applying)
- Temporary Renewal - \$50.00
- License Renewal - \$200.00

Arkansas State Medical Board:

- Trent P. Pierce, M.D., Chairman
- Peggy Pryor Cryer, Executive Secretary



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS and Centralized Credentials Verification Service

www.armedicalboard.org

_____ Medicine/Surgery _____ Osteopathic Medicine/Surgery _____ Education License

1. Name _____ Social Security # _____
(Legibly Print full Legal Name)

2. Name as listed on your Driver's License or Passport: _____

Driver's License State and Number _____

3. Address _____

4. Address you wish license to be mailed: _____

5. Phone (Res.) _____ (Work) _____ (Fax) _____ (email) _____

6. Male Female Birth Date ____/____/____ Birth Place _____ Race: _____

If born outside of U.S., how long have you lived in U.S. ____ Years ____ Months. Are you a citizen of U.S. ____ yes ____ no
If yes, and foreign born, attach proof of citizenship. If no, indicate your status with U.S. Immigration
(Attach copy of Visa/Work Permit)

7. ECFMG Certificate # _____ Date Issued _____

8. Intended practice location in Arkansas _____ Give name and address of hospital, clinic, group or private: _____

9. Specialty _____ Subspecialty _____
Board Certified (Date) _____ Board Certified (Date) _____
Recertification _____ Recertification _____

10. Drug Enforcement Administration Number _____ State _____ Expiration Date _____
State Controlled Substance License Number _____ State _____ Expiration Date _____
State Controlled Substance License Number _____ State _____ Expiration Date _____

Submit a copy of your DEA Registration Card and State Controlled Substance License to this office

11. UPIN # _____ Medicaid Provider # _____ Medicare Provider # _____
Accept Medicaid Patients? ____ Yes ____ No Accept Medicare Patients? ____ Yes ____ No

12. Professional Liability Insurance (**CURRENT** Carrier Name) _____

Policy # _____ Date of Expiration _____ Amount of Coverage _____
Send enclosed form to your insurance carrier and have them return directly to this office.

13. Medical School. Date Graduate _____ Mo _____ Day _____ Yr _____ Degree _____

	Name of Institution	Address	Date from	Date to
1 st Year				
2 nd Year				
3 rd Year				
4 th Year				

Have Verification of Medical Education Form and an official Transcript mailed directly to this office.

FOR USE OF SECRETARY ONLY

License No. _____

Name _____

Application for License through endorsement by _____

Application received _____

Fees _____ Date _____

License issued _____

Application Declined _____

Fees returned _____ 20____

NOTE: Application must be legible and completed in INK or Typed

14. Post Graduate Training (list chronologically). **Send Enclosed Verification Form – Refer to Instruction Sheet**

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No

15. Fellowships (list chronologically). **Send Enclosed Verification Form – Refer to Instruction Sheet**

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No

16. Circle which licensing exam you have taken: **USMLE** **NBME** **FLEX** **NBOME** **COMPLEX** **LMCC**

- or -

State Board Examination – State _____ **Year** _____ **(Taken prior to 1975 only)**

17. Have you taken the SPEX exam in the last five years? ____ Yes ____ No **If yes, have certified copies of scores mailed directly to this office.**

18. Military Service? ____ Yes ____ No If yes, which Branch? _____

Dates of Service _____ **Attach copy of separation papers and have records sent from Military Personnel Records Center. (See Instruction Sheet and Verification form.)**

19. List all states/countries in which you have or have had a medical license. **Have verification of each license mailed directly to this office. Send enclosed verification of Licensure Form. (Form may be copied if necessary.)**

State/Country	License #	Date Issued	Active Y/N	State/Country	License #	Date Issued	Active Y/N

20. Professional References/Recommendations: **Have three physician (M.D. or D.O.) reference/recommendation letters mailed from their offices directly to this office.** These cannot be current partners or related to you. They must have worked with you and directly observed your professional performance in the recent past. At least one of these references/recommendations must have had organizational responsibility for supervising your performance (i.e. department chief, service chief or training program director).

Name	Address	Association

Attach explanation of any "yes" answers. Refer to Instruction Sheet for the following questions.

YES NO

- | | | |
|--|-------|-------|
| 22. Have you ever failed any licensing exam, or any part of a licensing exam, which caused you to retake it? Which exam (USMLE, NBOME, etc.)? | _____ | _____ |
| 23. Has your application for examination or licensure ever been rejected, denied or withdrawn? | _____ | _____ |
| 24. Has any medical licensing board ever placed your license on probation, suspension or has it revoked a license or certificate it had granted you? If yes, list name and address of board.
_____ | _____ | _____ |
| 25. Have you ever been ordered to appear before a state medical board for any reason other than licensure? | _____ | _____ |
| 26. Have disciplinary procedures ever been initiated toward you by either a medical board or hospital? Explain. | _____ | _____ |
| 27. Have your privileges at any hospital been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? | _____ | _____ |
| 28. Have you ever voluntarily surrendered your license in any state? | _____ | _____ |
| 29. Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.) | _____ | _____ |
| 30. Have you ever been denied provider participation in any state or Federal Medicaid program? | _____ | _____ |
| 31. Have you ever previously made application to the Arkansas State Medical Board? | _____ | _____ |
| 32. Have you ever been warned, censured by, or requested to withdraw from, any hospital in which you have trained, been a staff member or held hospital privileges? If yes, explain. | _____ | _____ |
| 33. Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during an internship, residency or fellowship program? If yes, explain. | _____ | _____ |
| 34. Have you ever, voluntarily or involuntarily, left a training institution program before completing it? If yes, explain. | _____ | _____ |
| 35. Have you ever been reported to the National Practitioners Data Bank or subject to NPDB adverse action report? | _____ | _____ |
| 36. Have you resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted? | _____ | _____ |
| 37. Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending? | _____ | _____ |
| 38. Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicaid programs? If yes, name state _____ | _____ | _____ |
| 39. Have any malpractice claims been filed against you? If yes, provide official documentation from your attorney or insurance company.
a. How many? _____
b. How many were dismissed with settlement? _____
c. How many were dismissed or dropped? _____
d. How many are pending? _____ | _____ | _____ |
| 40. Have you ever been cited by a peer review organization? Explain
Give the name and address of the organization _____ | _____ | _____ |
| 41. Have you ever had to discontinue practice for any reason for a period longer than one month? If yes, explain. | _____ | _____ |
| 42. Have you been, or are you presently, being treated for alcoholism, or substance abuse? If yes, was this voluntary or the result of a medical board action? Explain. | _____ | _____ |
| 43. Do you currently, or have you had, any physical or mental health condition, including alcohol or drug dependency, which with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately? | _____ | _____ |

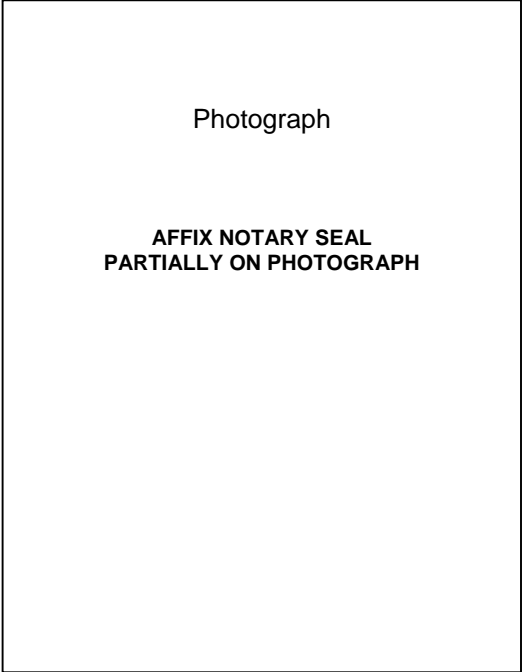
YES NO

44. Have you ever had a DWI? How many? _____ Date(s) occurred _____
45. Have you ever been treated for drug or substance abuse outside a hospital setting? Explain.
46. Have you ever been treated for drug or substance abuse in a treatment center or hospital? Give name of institution, date and length of stay? _____
47. Are you currently being, or have you ever been, monitored by a Physician Health Committee in any state? If yes, give state(s) _____ Ask your treating physician to send documentation of your status.
48. Have you ever been rejected by a medical society?
49. Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? If yes, explain.
50. Have you ever defaulted on any Health Education Assistance Loan? If yes, explain.
51. To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? If yes, explain.

If, during the application process, you become aware of any such investigation, you are required to report it to this office.

AFFIDAVIT OF APPLICANT

I, _____, certify after being sworn, that all of the information supplied in the foregoing application is true, correct, current and complete to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation or denial of any license to practice medicine granted to me, and criminal prosecution to the fullest extent of the law.



Applicant's Signature (in INK)

Date Signed

Sworn to and subscribed before me this _____

day of _____, **20** _____.

My Commission Expires: _____

Signature of Notary Public

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

CENTRALIZED CREDENTIALS VERIFICATION SERVICE INFORMATION PAGE

Overview: The Arkansas State Medical Board licensure application serves a dual purpose in Arkansas. Information collected at licensure will also be utilized in the Centralized Credentials Verification Service (CCVS) based in the Arkansas State Medical Board. Once licensed, you will automatically be enrolled in the CCVS and will remain a participant as long as you live, work or are affiliated with credentialing organizations in Arkansas. An annual printout listing the information that will be made available, upon your authorization, to credentialing/healthcare organizations will be mailed to your address on file with the ASMB. You will receive the CCVS printout and CCVS renewal several weeks prior to your birth month each year. Be sure the Board is notified of your current address. By Act 1410 of 1999, you are required to review this printed information, complete and return the designated pages with any amendments/changes or additions legibly marked, adding a current copy of your curriculum vitae (CV), so your CCVS file will be verified and updated. If there is information in your file that you disagree with, a copy of that section should be returned to the CCVS with your comments. Maintain copies of the CCVS printouts in your personal file for reference purposes.

The following information is released to the credentialing/healthcare organizations **only with your written authorization:**

- | | |
|----------------------------------|-------------------------|
| 1. Education | 9. Specialty Board |
| 2. Professional History | 10. DEA |
| 3. License Information | 11. Military History |
| 4. Federation/Medicare/Medicaid | 12. Current Malpractice |
| 5. Address & General Information | 13. Board History |
| 6. AMA/AOA Information | 14. Special Condition |
| 7. Criminal Convictions | (mental/emotional, |
| 8. ECFMG Information | physical, drug/alcohol) |

History: In 1993, the Arkansas General Assembly established the Arkansas Health Resources Commission. The Governor directed this Commission to review health care delivery in Arkansas and identify opportunities to contain costs and make procedures more efficient and effective. Based on its study, the Health Resources Commission offered various recommendations to the Governor. Of these, only one -- a statewide Centralized Credentials Verification Service -- was acted upon during the 1993 Legislative Session.

The Health Resources Commission recommended that a comprehensive Credentials Verification Service be based in the Arkansas State Medical Board. The Commissioners were of the opinion that the Medical Board, which is the entity already charged with collecting and verifying items needed for medical licensure in Arkansas, would be able to build on existing procedures for licensing

physicians. By broadening its scope, the Medical Board could obtain many of the additional items needed by healthcare organizations for credentialing physicians. Act 1066 of 1995 created the Board's Centralized Credentials Verification Service (CCVS). Arkansas became first in the nation to base a centralized credentials verification service with the state licensing agency. This state law allows the Arkansas State Medical Board to release, with a practitioner's written authorization, credentialing information needed by credentialing/healthcare organizations. The credentialing information furnished by the Board to a credentialing/healthcare organization shall be used solely for the purpose of credentialing and the renewal of credentials.

In 1999, Act 1410 was passed, replacing Act 1066. Act 1410 mandates physicians, clinics, hospitals, or other healthcare organizations, managed care organizations, insurer or health maintenance organizations or all other organizations credentialing physicians in Arkansas to use the CCVS to obtain credentialing information. The CCVS was surveyed by the National Committee for Quality Assurance (NCQA) on June 4-5, 2001 and received notification that certification in all eight of the requested eight verification elements was approved. The mandate for credentialing organizations became effective January 1, 2002.

The CCVS has oversight from a 10 member Advisory Committee appointed by the Medical Board. The Committee is comprised of representatives of credentialing/healthcare organizations subject to the act. The Advisory Committee was appointed to accomplish several functions. The functions include: 1) assisting the Medical Board in instituting a comprehensive and credible credentials verification service; 2) monitoring and evaluating the service and seeking opportunities to improve it; 3) providing liaison and facilitating compliance with regulatory standards such as those of NCQA, JCAHO, and the Arkansas Department of Health; 4) recommending policies, procedures and fees; and 5) publicizing and advocating for the service.

Continuing Education: Please be advised that when you receive your annual physician license renewal it will also include your CCVS renewal. You are required to complete both renewals and return promptly to the Board. DO NOT wait until the last minute to renew your license, as late fees may have accrued. Your renewals will include attestations regarding your CME activities for the year. You will sign one CME attestation for the CCVS and one for the Board. At this time, the CCVS is not collecting copies of certificates of CME activity. However, the Board or the CCVS may contact you and request you provide copies of your CME activity at any time. You are required to maintain a file of all your CME activities and make these available on request. Organizations where you are requesting privileges may also ask you to provide these copies to them.

The Medical Board consists of three major areas, Licensing, Regulatory and Centralized Credentials Verification Service (CCVS), each having its own processes, procedures and requirements.

If you have any questions regarding the Centralized Credentials Verification Service, call 501/296-1952 or email the CCVS directly at ccvs@armedicalboard.org

INSTRUCTIONS FOR COMPLETING APPLICATION

Please Type or Print (black or blue ink) and Answer All Questions – Do Not Leave Any Questions Blank on the Application.
Indicate Not Applicable (N/A) if the question is not applicable to you.

QUESTION 1:

Enter your legal name. If your name has changed due to marriage, divorce, adoption or naturalization, submit a notarized copy of pertinent document. Enter your Social Security Number to be used for identification.

QUESTION 2:

Enter your name as it is listed on your Driver's License or Passport. Enter the Driver's License state and number. Include a copy of these documents.

QUESTION 3:

Enter your Current Mailing Address.

QUESTION 4:

Enter the Mailing Address where you wish your Arkansas License to be mailed.

QUESTION 5:

Enter your Residence, Work, Telephone/Fax Numbers and your email address.

QUESTION 6:

Check whether you are male or female and indicate your Birth Date, Birth Place and Race – If Born outside the U.S., enter how long you have lived in U.S. - Indicate whether you are a citizen of U.S. – If Yes, and Foreign born, attach proof of citizenship. – If No, indicate your status with U/S. Immigration and attach copy of your current Visa or Work Permit.

QUESTION 7:

Enter your ECFMG Certificate Number and Date Issued. Have certification of your standing with ECFMG mailed direct to this office. Complete the online Request for Status Report of ECFMG Certification. (See web address information sheet)

QUESTION 8:

Enter the location you plan to practice in Arkansas and also indicate the name and address of hospital, clinic or group. Request that your future employer send a letter of intent to employ.

QUESTION 9:

Enter your Medical Specialty and Subspecialty. – Indicate whether you are Board Certified in that Specialty. If Yes, give Date of Certification and Recertification; complete enclosed form and mail to your Specialty Board. (Check with them, as a fee may be required.)

QUESTION 10:

Indicate your DEA number, the state you are registered in and the expiration date. If you are registered in more than one state indicate that in writing by attaching another sheet. – Submit a copy of your DEA Registration Card to this office. If you have any state controlled substance licenses, include copies of those as well.

QUESTION 11:

Indicate your Universal Physician Identification Number, your Medicaid Provider Number and your Medicare Provider Number.

QUESTION 12:

Enter the Name of your current Liability Insurance carrier and your Policy Number. Send the enclosed request form to your insurance carrier.

QUESTION 13:

Enter your Graduation Date (month, day and year) and the Degree granted. Indicate the name and address of your Medical School and the dates attended for each year. List each Medical School you have attended. Send the enclosed Verification of Medical Education Form to your Medical School. Complete the top portion of the Verification Medical Education Form and **ATTACH A RECENT PASSPORT SIZE PHOTO** in the space indicated on the lower right corner. Mail this form to your Medical School for the certification with instructions to complete and forward directly to this office. No Medical Education Verification Forms will be accepted without a recent photo attached. Any forms received without the applicant's photo will be rejected and the verification will have to be redone. In addition to the Medical Education Verification Form, you will need to have your Medical School include a Certified copy of your Transcript. (Copies of documents or certificates of your foreign training or medical activities cannot be accepted for verification.)

QUESTIONS 14 AND 15:

List chronologically your Internship, Residencies and Fellowships. (Name of the Institution, Address, Type of Program, whether completed and the to and from dates.) Mail the enclosed postgraduate training verification form to all the institutions where you trained or are training. Ask your program director or department head to complete the form and mail it directly to this office.

QUESTIONS 16:

Circle which licensing exam you have taken. For all circled responses, have a certified copy of those scores sent directly to this office. If you have indicated you have taken a state board exam, indicate which state and the date of exam. (State Board exams taken after 1975 are not acceptable for licensure in Arkansas.) (See web address information sheet)

QUESTION 17:

Indicate if you have or have not taken the SPEX exam in the last five years. If you answered "Yes", you will need to have a certified copy of the scores sent directly to this office and provide a written explanation for why SPEX was taken. (See web address information sheet)

QUESTION 18:

Indicate if you have ever been in the military (whether foreign or in the United States) and if so, which branch and the dates of service. Attach a copy of your separation papers (DD-214) and contact the military personnel records center for verification of dates of service, verification of military hospitals, disciplinary problems, drug or substance abuse or mental or emotional impairments. (See web address information sheet)

QUESTION 19:

List all states and countries where you currently hold, or held, a license (including any temporary or training permits). Indicate license number, date issued and whether it is active. Complete the top portion of Verification of Licensure Form and send to each of these licensing boards to complete and return directly to this office. *Check with these boards prior to mailing, as they may require a fee.*

QUESTION 20:

List the name, address and your association with, three physicians (M.D. or D.O.) who can recommend you and ask them to send a letter directly to this office. These recommendations may not be current partners, or related to you. They must have worked directly with you and directly observed your professional performance in the recent past. At least one of these recommendations must have had organizational responsibility for supervising your performance (i.e. department chief, service chief or training program director.) **Please communicate the following guidelines for submitting recommendation letters to the Board:**

- Letters must be written/typed on standard size paper or letterhead and must include the date, address and phone number of the sender. The name of the sender must be *legibly* printed or typed on the letter.
- Letters must be addressed to the Arkansas State Medical Board and state they are recommending you for licensure in Arkansas.
- Letters must include your full, legal name. If an alternate name, nickname or the English translation is used, your full, legal name must be included in the letter.
- Letters from the same organization cannot be identical “form” letters and should be mailed separately.

QUESTION 21:

Indicate, in chronological order, the “from” and “to” dates, your type of privileges, institution name and address and the position held, of all your professional activities, institutional affiliations or places of employment since graduation from Medical School. (This includes clinics, hospitals, teaching institutions, HMO’s, private practice, employment, corporations, military assignments, government agencies, contract, moonlighting and locum tenens assignments. Exclude residencies and fellowships previously listed. Attach additional sheets after completing this section, if necessary.) Send enclosed verification of hospital/clinic forms to the appropriate institutions for verification of privileges and employment. All others have a letter of verification of dates mailed directly to this office. *Do not submit Curriculum Vitae (CV) in lieu of completing this section.*

QUESTIONS 22 THRU 51:

Answer yes or no to all of these questions. Attach a detailed explanation for any “Yes” answer.

Special Instructions:

#29 – Misdemeanor or Felony conviction – attach explanation and copy of original indictment, judgment or conviction, indicate whether paroled or placed on probation and how probation was completed. Please note that if you have a record that is sealed, expunged or pardoned, you are still required to answer “yes” to this question.

#39 – Malpractice claims – list the number of claims, the number dismissed with settlement, the number dismissed or dropped without settlement and the number that are pending. Ask your insurance company or attorney to furnish us with copies of the original complaint, the answer and the disposition or settlement of each claim. If dismissed without settlement, we only require a copy of the court document indicating dismissal. You will also need to include your written version of each claim.

#47 – Physicians’ Health Committee – indicate whether you are currently, or have ever been, monitored by Physician Health Committee in any state or country. If “yes”, list state or country and furnish a letter from the director of your program verifying your status. Have him include a copy of your contract. You will need to sign and return to the Board, the enclosed Physicians’ Health Committee Authorization and Release. Also, you will need to contact the Arkansas Physicians’ Health Committee:

Arkansas Physicians’ Health Committee
Arkansas Medical Foundation
10 Corporate Hill, Suite 150
Little Rock, AR 72205
(501) 224-9911

AFFIDAVIT OF APPLICANT:

Attach a signed and dated, recent passport size photo in the space provided. Sign the application before a Notary Public, swearing that you are the person referred to in the application and that all statements contained therein are true and correct.

TIME GAPS:

Once your file is complete, a final review will be done. Any gaps in time over thirty (30) days must be accounted for. You will be notified of these dates and will be required to submit accountability in writing, listing the dates exactly as are provided to you and request additional verifications, if necessary. Your signed and dated response can be mailed or faxed to this office.

RELEASES:

The Arkansas State Medical Board requires that the applicant sign each verification form. (Copied signature on multiple, like forms is ok.) Any verification received that has “see release”, or is signed by another individual on behalf of the applicant will not be accepted and the verification will have to be redone.

NO APPLICATION WILL BE ACCEPTED WITHOUT THE \$400.00 FEE AND \$100 PROCESSING FEE

This can be a personal or business check or money order.

ARKANSAS STATE MEDICAL BOARD REQUIREMENTS FOR M.D./D.O. LICENSE

- You must be twenty-one years of age
- You must be of good moral character and have not been guilty of acts constituting unprofessional conduct, as defined in Arkansas Medical Practices Act Sec. 17-95-409
- You must complete a background check as defined in Arkansas Medical Practices Act Sec. 17-95-306
- You must be a graduate of an approved medical school and request your school provide a certified copy of your transcript to this board
- You must have completed at least ONE (1) year of internship or residency in an ACGME approved program in the United States
- Present Indisputable Identification
- Licensure fee of \$400 and processing fee of \$100 (\$500 total) is required at application

LICENSURE IS BY CREDENTIALS:

- Credentials must be verified from the originating source, verifications received from applicants will be returned

LICENSING EXAMINATIONS MEETING THE BOARD REQUIREMENT ARE AS FOLLOWS:

- FLEX, National Boards, USMLE, National Board of Osteopathic Exam; COMLEX, LMCC or State Exams taken prior to 1975

IF YOU ARE AN INTERNATIONAL MEDICAL GRADUATE, YOU MUST ALSO PROVIDE:

- Verification of Clinical Clerkships
- Certification by ECFMG and demonstrate in a personal interview the ability to read, write and speak English fluently and also demonstrate adequate training and ability sufficient to permit the practice of medicine in accordance with accepted medical practice in the state of Arkansas
- Completion of at least THREE (3) years of internship or residency in an ACGME approved program in the United States – OR – completion of at least ONE (1) year of internship or residency in an ACGME approved program in the United States AND be currently enrolled in a training program with the University of Arkansas for Medical Sciences

IF YOUR ARE APPLYING FOR AN EDUCATIONAL LICENSE:

Pursuant to Act 497 of the 85th General Assembly of the Regular Session of 2005, the Arkansas State Medical Board is empowered to issue an educational license to applicants who meet the following requirements:

1. Be 21 years of age
2. Be of good moral character
3. Submit a completed application to the Board
4. Submit a \$400.00 application fee and a \$100.00 licensure-processing fee
5. Appear personally before the Arkansas State Medical Board, together with the sponsoring physician from the University of Arkansas for Medical Sciences Department where the applicant will be practicing medicine
6. Present to the Board such information as to what department of the University of Arkansas for Medical Sciences he or she will be practicing medicine and who will be his/her supervisor
7. Said educational license will authorize the licensee to practice medicine only within the clinical and educational programs established and administered by the University of Arkansas for Medical Sciences
8. Said educational license will be valid for a period of one (1) year from the date of issuance

The educational license issued to a licensee will lapse at the end of one year and must be re-applied for by the licensee under the following conditions:

1. Submit a completed application to the Arkansas State Medical Board providing such information as the Board requests
2. Pay a renewal fee of \$200.00
3. Appear in person before the Board, together with the Chairman of the clinical or educational program wherein the applicant will be practicing medicine at the University of Arkansas for Medical Sciences

Completed application, fee and documentation should be sent to:

ARKANSAS STATE MEDICAL BOARD
2100 RIVERFRONT DRIVE
LITTLE ROCK, AR 72202



**American Medical Association
Profile Request**

<https://profiles.ama-assn.org/amaprofiles/>



**National Board of Medical Examiners
Request for Endorsement of NBME Certification**

<http://www.nbme.org/pdf/endorse.pdf>



**Federation of State Medical Boards
USMLE, FLEX, SPEX Transcript
Request for EXAMINATION AND BOARD ACTION HISTORY REPORT (EBAHR)**
<https://secure.fsmb.org/trol/>



**National Board of Osteopathic Medical
Examiners, Inc.
Transcript Request Form**
<http://www.nbome.org/>



**American Osteopathic Association
Profile Request**
<https://www.doprofiles.org/>



**Education Commission for Foreign Medical Graduates
Request for Status Report of ECFMG Certification**
<https://cvsonline2.ecfm.org/>

**CONTACT THE APPLICABLE ORGANIZATION'S
WEBSITE TO REQUEST THE REQUIRED
VERIFICATIONS BE SENT TO:**

**Arkansas State Medical Board
Attention: Licensing Department
2100 Riverfront Drive
Little Rock, AR 72202**



**National Personnel Records Center.
To Request Military Service Records or Prove
Military Service**
[http://www.archives.gov/veterans/military-
service-records/get-service-records.html](http://www.archives.gov/veterans/military-service-records/get-service-records.html)



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF MEDICAL EDUCATION

Name of Institution _____

Street _____

City _____ State _____ Zip _____

I, _____, M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the application process, the Arkansas State Medical Board requires verification of my **Medical Education**.

I hereby authorize _____, its staff, or representative to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____
(Signature of Applicant)

Date or Birth ____ / ____ / ____
MO DAY YR

Social Security Number _____

Date of Graduation ____ / ____ / ____
MO DAY YR

For verification of MEDICAL EDUCATION ONLY
Please provide exact date.

The following section must be completed by the dean or registrar of the medical or osteopathic school and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted.** Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.

This certifies that _____
(Full name of applicant)

Enrolled in _____
(Name of medical or osteopathic school)

on ____ / ____ / ____ graduated ____ / ____ / ____ with a degree in _____
MO DAY YR MO DAY YR

Further, the records of this institution indicate that the attached photograph
(Check one) Represents a true likeness of the above named applicant.
 Does not represent a true likeness of the above named applicant.

AN OFFICIAL SCHOOL TRANSCRIPT MUST BE RETURNED WITH THIS FORM

By _____
Signature of the dean or registrar **(NO STAMPED SIGNATURES ACCEPTED)**

SEAL

Attach
Passport size
Photograph
here

Print or Type Name of dean/registrar _____

Signed and the college Seal affixed on ____ / ____ / ____
MO DAY YR

Phone (____) _____ Fax (____) _____

Medical school seal MUST be imprinted partially on photograph.



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF POSTGRADUATE TRAINING

Name of Program Director _____

Name of Institution _____

Street _____

City _____ State _____ Zip _____

I, _____, have applied for a license to practice medicine in the State of Arkansas. As part of the application process, the Arkansas State Medical Board requires a reference from the program director of each ACGME accredited **Postgraduate Training** program to which I have been appointed.

I hereby authorize _____, its staff, or representative to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and /or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____

Date of Birth _____ / _____ / _____ Social Security Number: _____

For verification of POSTGRADUATE TRAINING Please provide exact date(s).

The following section must be completed by the Program Director or his/her representative and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted. DO NOT USE SIGNATURE STAMPS.**

This is to certify that _____, a graduate of _____

commenced postgraduate training (*internship/residency/clinical fellowship) in _____

on _____ / _____ / _____ and completed (check one) successfully **unsuccessfully such training on _____ / _____ / _____,

or anticipated graduation date on _____ / _____ / _____.

Internship- Name of Dept./Dates _____

Residency- Name of Dept./Dates _____

Fellowship-Name of Dept./Dates _____ Clinical Research

Type or Legibly Print Name: _____ Signature: _____

(DO NOT USE SIGNATURE STAMPS)

Date Signed _____

Title _____

Tel. No. () _____ Fax No. () _____

COMMENTS: _____

***List the reason for unsuccessful completion in Comments or attach a letter of explanation.*

*Circle one.



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

Name of Institution _____

Street _____

City _____ State _____ Zip _____

I, _____, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)

the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize _____, its staff, or representative to provide the Arkansas State Medical Board
(Name of Hospital)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, _____

Date of Birth ____ / ____ / ____
MO DAY YR

Social Security Number _____

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, _____ state that the above named physician has/had the following staff privileges
(Print Full Name)

(Circle One): Courtesy - Active Staff - Temporary - Other _____, at our hospital/clinic from ____ / ____ / ____ to ____ / ____ / ____.
MO DAY YR MO DAY YR

Indicate the scope of Clinical Privileges, if any: _____

During the stated period of time, the clinical privileges of this individual (check one) Were Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) Would Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Signature

Title

Date Signed (MO/DAY/YR) Email address: _____

(_____) _____
Telephone Number

(_____) _____
Fax Number



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF LICENSURE

I, _____, MD/DO, hereby authorize and request the state/country board of _____, having control of any documents, records, and other information pertaining to me, to furnish to the Arkansas State Medical Board all information requested on this form and any pertinent information regarding final actions taken against my license to practice Medicine and Surgery or Osteopathic Medicine and Surgery.

Signature of Applicant	License Number	Issue Date ____/____/____ MO DAY YR
Name in full (Please print or type)	Date of Birth ____/____/____ MO DAY YR	Social Sec. No. ____-____-____
Other Names used in obtaining licensure		
Current Address		

For verification of LICENSURE
Please provide exact dates.

The following section must be completed by an official of the state/country board and returned directly to the ASMB. Any substitution must contain the same information and mailed directly from the state board or it will not be accepted for verification purposes. State Seal must be affixed to be accepted.

State/Country of	Full name of licensee	
Graduate Of	License Number	Issue Date ____/____/____ MO DAY YR
Expiration Date ____/____/____ MO DAY YR	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed <input type="checkbox"/> Other (Explain on back)	

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Has the applicant ever been warned, censured, or disciplined in any manner by a licensing or disciplinary authority in your state?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please provide date(s) _____/_____/_____, _____/_____/_____ | | |
| 2. Has his/her application for initial licensure or reinstatement ever been denied or withdrawn? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please provide date(s) _____/_____/_____, _____/_____/_____. | | |
| 3. Is this physician currently under investigation by your state board? | <input type="checkbox"/> | <input type="checkbox"/> |

Comments, if any (may attach additional sheets)

Board Seal must be affixed	Legibly Print Name and Title	Date
	Signature:	____/____/____ MO DAY YR
State/Country Board Name and Address Phone () Fax ()		



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX: (501) 296-1972

www.amedicalboard.org

PROFESSIONAL LIABILITY VERIFICATION

Name of Institution _____

Street _____

City _____ State _____ Zip _____

I, _____, M.D./D.O. have applied for a license to practice medicine in the state of Arkansas. As part of the application process, the Arkansas State Medical Board requires verification of my current **Liability Insurance**.

I hereby authorize _____, its staff, or representative to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named company and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____ Social Security Number _____
(Signature)

Date of Birth _____ / _____ / _____
MO DAY YR

For verification of PROFESSIONAL LIABILITY

The following section must be completed by the executive director/secretary or his/her representative and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted for verification purposes.**

This certifies that _____
(Full name of applicant)

(Carrier) (Certificate or Policy Number) (Policy Amount)

Dates of Coverage _____ to _____
MO/DAY/YR MO/DAY/YR

Coverage type: Occurrence-based Claims-based Tail coverage? Yes/No

YES NO

Have any specific procedures been excluded from this coverage? If yes, please list the procedures. _____

Has your insurance company defended this provider in any professional liability suits? _____

Does your insurance company have presently pending any judgements or settlements on behalf of the provider? _____

Has your insurance company paid judgement or settlements on behalf of the provider? _____

If the answer to any question is "Yes" please provide a full explanation of the details on a separate sheet, including the name of the court in which the suit was filed, the caption and docket number of the case, the name and address of the attorney who defended this physician, to be returned with this letter.

Type or Legibly Print Name _____ Signature _____

Title _____ Date Signed _____ Phone (____) _____ Fax (____) _____



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF SPECIALTY BOARD

Name of Specialty Board _____

Street _____

City _____ State _____ Zip _____

I, _____, have applied for a license to practice medicine in the State of
(Print full name)

Arkansas. As part of the application process, the Arkansas State Medical Board requires verification of my **Specialty Board**.

I hereby authorize _____, its staff, or representative to provide the Arkansas State
(Name of Institution)

Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named board and/or person for any and all acts performed in fulfilling this request, provided such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____
(Signature of Applicant)

Date of Birth ____ / ____ / ____
MO DAY YR

Social Security Number _____

For verification of SPECIALTY BOARD

The following section must be completed by the executive director/secretary or his/her representative and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted for verification purposes.**

This is to certify that _____
(Full name of applicant)

was certified on _____, to _____
Month Day Year Month Day Year

Recertification date _____ Certificate Number _____

Legibly Print or Type Name

Signature

Title

Date Signed

(_____) _____ (_____) _____
Phone Number Fax Number



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.amedicalboard.org

ARKANSAS RULES AND REGULATIONS AFFIDAVIT

I, _____ on this date, _____
(Type or Print Name)

do affirm that I have read the Medical Practices Act, Arkansas Code 17-95-101, *et seq.*, and the Rules and Regulations of the Arkansas State Medical Board.

Signed: _____
(Physician's Signature)

Date: _____

THIS IS A REQUIREMENT FOR LICENSURE. YOU MUST COMPLETE THIS FORM AND RETURN IT TO:
ARKANSAS STATE MEDICAL BOARD
ATTN: LICENSING
2100 RIVERFRONT DRIVE
LITTLE ROCK, AR 72202-1435



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, AR 72202-1435 (501) 296-1802
www.armedicalboard.org

AUTHORIZATION AND RELEASE

To Whom It May Concern:

This document will authorize and direct any physicians with whom I have been associated, employees and medical staff members of any medical facility or hospital where I have been employed or on staff or associated, or any employees of any malpractice insurance carriers, or any state medical licensing boards where I have been licensed or have applied for a license, or any medical clinics where I have been employed or associated, or any medical schools where I have attended, to give to, copy for, or permit the personal inspection by employees or representatives of the Arkansas State Medical Board of any and all personnel records, disciplinary records, work records, military records, professional performance reviews, evaluations of my performances.

I hereby release and discharge you and any other individuals or organizations referred to in this Authorization, and release you of any confidentiality requirements that might bind you, so that you may carry out the purposes of this document.

A copy of this document* may be provided to entities listed above, and this Authorization shall remain in effect for a period not to exceed two (2) years or until specifically revoked by me in writing.

Typed or Printed Name of Physician: _____

Social Security Number: _____

Signature of Physician (Black or Blue Ink Only): _____ Date: _____
(Do not use signature stamps)

*** This document does not authorize the Arkansas Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas law.**



ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF CLINICAL CLERKSHIP (International Medical Graduates Only)

Name of Institution _____

Street _____

City _____ State _____ Zip _____

I, _____, M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the application process, the Arkansas State Medical Board requires verification of my **Clinical Training**.

I hereby authorize _____, its staff, or representative to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Suite 200, Little Rock, Arkansas 72202. I understand completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____
(Signature of Applicant)

Date or Birth ____ / ____ / ____
MO DAY YR

Social Security Number _____

Date of Graduation ____ / ____ / ____
MO DAY YR

For verification of CLINICAL CLERKSHIP ONLY Please provide exact dates.

The following section must be completed by the instructor/program director (circle one) or his/her representative and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted.** Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.

This certifies that _____, _____
(Full name of applicant) (Medical School)

participated in a clinical clerkship offered by _____
(Legibly print or type name and address of facility)

from ____ / ____ / ____ through ____ / ____ / ____ in the clinical area of _____. This student successfully completed said clerkship on ____ / ____ / ____.

I, _____, being duly sworn, state that I was the instructor/program director (circle one) for the above named student during the clerkship OR _____, being duly sworn, says that he/she ___ was or ___ was not the individual instructor or Program Director for the student named above during the clerkship indicated, and/but that he/she has carefully read the completed form and the statements made herein are strictly true in every respect and that the attached photograph:

- (Check one) Represents a true likeness of the above named applicant.
 Does not represent a true likeness of the above named applicant.

Type or Print Name & Title of instructor/program director, authorized representative

**AFFIX SCHOOL
SEAL PARTIALLY
ON PHOTOGRAPH
AT RIGHT**

*Attach
Passport size
Photograph
here*

Signature _____

Telephone _____ Fax _____

Date Signed _____
Month Day Year

**AUTHORIZATION AND RELEASE
(PHYSICIANS' HEALTH COMMITTEE)**

To Whom It May Concern:

This document will authorize and direct the Arkansas State Medical Board and its employees to give to, copy for, or permit the personal inspection by the Arkansas Physicians' Health Committee, any and all records concerning my drug/substance abuse, rehabilitation, contracts with other Physician Health Committees and medical reports or evaluations of performance.

I hereby release and discharge the Arkansas State Medical Board and any other individuals or organizations referred to in this Authorization and Release of any confidentiality requirements that might bind you and hereby release you from any and all liability or claims of any nature in connection with the authorized release of information furnished to the Arkansas State Medical Board.

A copy of this Authorization and Release shall remain in effect until specifically revoked by me in writing.

Typed or Printed Name of Physician: _____

Signature of Physician: _____ **Date:** _____