



ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201-2936

Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org

Julia Feazell, P.A. Licensing Coordinator, (501) 296-1955, jdf@armedicalboard.org

PHYSICIAN ASSISTANT LICENSURE INFORMATION PACKET

This packet contains all of the documents you will need to apply for a license in Arkansas. This packet, as well as each of its components, is available in the Forms & Publications section of our web site, www.armedicalboard.org/forms.aspx. If you received this packet from a source other than directly from the Arkansas State Medical Board or its official website, the application may be outdated or not an official version. Please be advised that outdated or unofficial versions of the application cannot be accepted.

*** IMPORTANT INFORMATION - PLEASE READ CAREFULLY ***

PROCESSING TIME. Processing delays are almost always attributable to lengthy work histories and delays in receiving the verification documents you request. If you have a history of malpractice, disciplinary action, impairment history, etc., additional time will be required for our investigation. Processing a permanent license application will take several weeks to complete. Please plan for this. Do not make commitments, purchase a home, or relocate your family before your Arkansas Physician Assistant license has been granted. Applications are processed in the order in which they are received in our office. The board does NOT accelerate one applicant over another. Upon receipt of your completed application, it will be entered into our system and then routed to the Licensing Coordinator. The Licensing Coordinator will send you a letter of acknowledgement within 7-10 business days after she receives your application. The letter will advise you of anything that is needed to complete your file at that point.

APPLICATION FEES. The fee for full licensure is **\$90**. (\$80 application fee plus \$10 for temporary license), and must be included with your application at the time of submission. Payment may be made by check or money order payable to *ASMB*.

ARKANSAS MEDICAL PRACTICES ACTS AND REGULATIONS. The Arkansas Medical Practices Acts and Regulations must be read in their entirety prior to submitting an application for a Physician Assistant license to the Arkansas State Medical Board. You **MUST** complete the Rules & Regulations Affidavit located in this packet. Applications received without this form will be returned. The Medical Practices Act can be viewed and downloaded in the Forms & Publications section of our web site, www.armedicalboard.org/public/mpa.

CRIMINAL BACKGROUND CHECK. Act 1249 of 2005 authorizes the Arkansas State Medical Board to conduct criminal background checks (both state and federal) on ALL applicants for licensure.

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.*

Upon receipt in this office of your completed application and fee, a CBC packet, including forms and instructions, will be sent to you for completion. The Federal portion of this background check can take two weeks or more to process. ASMB will NOT accept a previously obtained criminal background check, regardless of how recently it was performed or what organization provides it.

COMPLETING THE APPLICATION. READ THE INSTRUCTIONS FOR EACH QUESTION BEFORE ANSWERING. The application may NOT be submitted electronically, as we do require your original signature on the hard copy. Please type or print legibly in dark blue or black ink. Provide exact dates (mm/dd/yyyy) whenever possible. ANSWER ALL QUESTIONS/ SECTIONS, even if your answer is “n/a,” “Not Applicable,” or “None.” All signatures must be the applicant’s; stamped signatures, signatures by proxy, and signatures by power of attorney are NOT accepted for documentation or verification purposes. Make sure all required seals are affixed on the application, all questions have a response, and all documentation has been certified. Your application and verifications will be returned to you if they are incomplete or if photos are not attached where required.

TIME GAPS. Any time gaps of more than 30 days since the beginning of Physician Assistant school must be explained in writing. You will be notified of any unexplained time gaps and asked to provide an explanation. To avoid processing delays, please include these with your original application.

“YES” RESPONSES. A “Yes” response in the Attestation portion of the application does not mean your application will be denied. If you have responded “Yes” to any question in the application, additional time will be required for the gathering and assessment of pertinent information. You will be required to provide a separate, signed and complete explanation for each “Yes” response; you can expedite this process by including these with your original application.

VERIFICATIONS. It is the policy of this board that ALL education, training, and professional affiliations and other activities since graduation from Physician Assistant school be verified by the primary source and reviewed by the full board prior to issuance of a permanent license. It is the applicant’s responsibility to request verifications and to follow up with organizations to ensure verifications are returned. All verifications will be accepted via fax or e-mail unless specifically requested to be mailed to the address on page 6. Applicants are required to sign verification documents where indicated in Part II prior to sending to verification source. The verifier’s signature can be original, stamped or computer-generated.

INTERNATIONAL GRADUATES. If you are foreign-trained, the Arkansas State Medical Board must have on file a copy of your current Visa or work permit.

CHECKING THE STATUS OF YOUR APPLICATION. Please be considerate of your Licensing Coordinator and minimize the number of phone calls to check on the status of your application. Repeated, unnecessary calls will only delay the processing time for all applicants. You may authorize the Arkansas State Medical Board to discuss the status of your application with ONE person other than yourself. The form for designating a contact person is included in this packet.

APPLICATION REVIEW. The application review process is defined by the requirements set forth in state law. The board and its staff must comply with those laws in processing applications. Applications are processed in the order in which they are received in our office. THE BOARD DOES NOT ACCELERATE ONE APPLICANT OVER ANOTHER.

TEMPORARY PERMITS. The Physician Assistant must take and successfully pass the NCCPA’s certifying exam before receiving a temporary permit. The earliest you may take the exam is seven (7) days after program graduation, and it may be taken only once in any 90-day period or three (3) times in a calendar year. A temporary permit may be granted to an applicant who meets all the qualifications for licensure but is awaiting the next scheduled meeting of the Physician Assistant Advisory Committee. The temporary permit will expire at the next scheduled meeting unless extended, and can be extended only once. The applicant must appear with his or her Supervising Physician for approval of protocol within four (4) months of when the first temporary permit was granted.

COMMITTEE APPEARANCE. All applicants and supervising physicians will be required to appear before the Physician Assistant Advisory Committee prior to licensure, and also when there is a change of supervising physicians. Licenses are granted ONLY at regularly scheduled meetings. Meeting dates may change at the discretion of the Committee or the Arkansas State Medical Board. Meeting dates are available on our website, www.armedicalboard.org. Completed application deadlines will be provided to you by your Licensing Coordinator.

U.S. POSTAL SERVICE. If you choose to utilize the U.S. Postal Service, please be advised that they do NOT guarantee delivery of first class mail, and they do NOT guarantee delivery of Certified mail. Based on the lengthy delays we have experienced in receiving mail that has been sent to us, we strongly recommend you utilize FedEx, UPS, or other *guaranteed* delivery service when sending your application or other documents to us. We further recommend that when sending verification requests to primary sources, you provide them with a prepaid FedEx, UPS or other delivery service envelope to ensure that their correspondence reaches us in a timely manner.

INACTIVE APPLICATIONS. Applications that are not complete after one year will be classified as Inactive and will be removed from our system. Inactive files will be maintained for 30 days and then destroyed. No refunds will be given on inactive applications over one year old.

WITHDRAWN APPLICATIONS. Applications that are withdrawn by the applicant will be maintained for 30 days and then destroyed. No refunds are given on applications that are withdrawn.

LICENSE RENEWAL. Your Physician Assistant license, if granted, must be renewed annually on or before the last day of your birth month. There is no grace period. License renewal paperwork is mailed approximately 8 weeks before expiration, to the address you have specified as your "Renewal Address". Failure to receive a renewal notice is not considered an excuse for nonrenewal. Renewal applications received after expiration will be assessed a \$25 late fee. It is illegal to practice as a Physician Assistant in Arkansas with an inactive or lapsed license or permit.

CHANGE OF ADDRESS. Regulation 33 requires you to notify the Arkansas State Medical Board of any changes to your address within 30 days of such change. This includes your relocation to Arkansas, if applicable. A Change of Address form is included in this packet.

PHYSICIAN ASSISTANT REQUIREMENTS FOR MEDICAL LICENSURE IN ARKANSAS

ARKANSAS MEDICAL PRACTICES ACTS AND REGULATIONS, 17-105-102 (b):

THE BOARD MAY GRANT A LICENSE AS A PHYSICIAN ASSISTANT TO AN APPLICANT WHO:

- (1) Submits an application on forms approved by the board;
- (2) Pays the appropriate fees as determined by the board;
- (3) Has successfully completed an educational program for physician assistants or surgeon assistants accredited by the Committee on Allied Health Education and Accreditation or by its successor agency and has passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA).
- (4) Certifies that he or she is mentally and physically able to engage safely in practice as a Physician Assistant;
- (5) Has no licensure, certification, or registration as a Physician Assistant under current discipline, revocation, suspension, or probation for cause resulting from the applicant's practice as a Physician Assistant, unless the board considers such condition and agrees to licensure;
- (6) Is of good moral character;
- (7) Submits to the board any other information the board deems necessary to evaluate the applicant's qualifications;
- (8) Has been approved by the board;
- (9) Is at least twenty-one (21) years of age; and
- (10) After July 1, 1999, has at least a bachelor's degree in some field of study from a regionally accredited college or university, unless the applicant has:
 - (A) Prior service as a military corpsman and is a graduate of a Physician Assistant education program recognized by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs or the applicant is currently certified by the National Commission on Certification of Physician Assistants.
 - (B) Was serving as a Physician Assistant in a federal facility located in the State of Arkansas on or after July 1, 1999, and who is a graduate of a Physician Assistant education program recognized by the Committee on Allied Health Education Programs;
 - (C) Was licensed in good standing on July 30, 1999, by the Arkansas State Medical Board; or
 - (D) Was enrolled on or before July 1, 1999 in a Physician Assistant program recognized by the Commission on Accreditation of Allied Health Education Programs.
 - (E) Show successful completion of the Jurisprudence examination as administered by the Arkansas State Medical Board covering the statutes and Rules and Regulations of the Medical Board, the Arkansas Medical Practices Acts & Regulations, the Physician Assistant Act, and the laws and rules governing the writing of prescriptions for legend drugs and scheduled medication;
 - (F) The submission and approval by the Board of a protocol delineating the scope of practice that the Physician Assistant will engage in, the program of evaluation and supervision by the supervising physician;
 - (G) The receipt and approval by the Arkansas State Medical Board of the supervising physician for the Physician Assistant on such forms as issued by the Arkansas State Medical Board.

LICENSURE IS BY CREDENTIALS:

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

LICENSING EXAMINATIONS MEETING THE BOARD REQUIREMENTS ARE AS FOLLOWS:

- Physician Assistant National Certifying Examination (PANCE)

ARKANSAS STATE MEDICAL BOARD:

- Trent P. Pierce, M.D., Chairman
- Peggy Pryor Cryer, Executive Secretary
- Business Hours: Monday-Friday 8:00 AM - 5:00 PM
- Regulatory Phone: (501) 296-1802
- Regulatory Fax: (501) 296-1805
- Mailing and Physical Address: 1401 W. Capitol Ave., Suite 340
Little Rock, AR 72201-2936

PHYSICIAN ASSISTANT LICENSING COORDINATOR:

Julia Feazell
Phone: (501) 296-1955
Fax: (501) 296-1805
E-mail: jdf@armedicalboard.org

ARKANSAS STATE MEDICAL BOARD WEB SITE: WWW.ARMEDICALBOARD.ORG

- Board Meeting Dates
- License Verifications
- Changes in Rules and Regulations
- Click on [Forms & Publications](#) to access the following at any time:
 - Arkansas Medical Practices Acts & Regulations
 - Application packet, including all required forms, and verification request forms

CURRENT FEES:

- Full License - \$90.00 (\$80 application fee plus \$10 for temporary license)
- Annual License Renewal - \$50.00
- Late Renewal Fee - \$25.00

LICENSE APPLICATION CHECKLIST

(Use this checklist to be sure your application is complete prior to sending to the Arkansas State Medical Board)

USE THE FOLLOWING ADDRESS FOR ALL DOCUMENT SUBMISSION:

ARKANSAS STATE MEDICAL BOARD
ATTN: JULIA FEAZELL
1401 W CAPITOL AVE, SUITE 340
LITTLE ROCK AR 72201-2936

You are required to provide the following documents to the Arkansas State Medical Board:

- Check or money order, made payable to *ASMB*, in the amount of \$90.00, for temporary and full licensure.
- Application (6 pages), signed, with photo attached and certification by Notary Public. Signature must be original and must be made in black or dark blue ink. Stamped signatures, signatures by proxy and signatures by Power of Attorney are NOT accepted.
- Signed and dated explanations for any "Yes" answers in Part IV of the Application
- Signed and dated explanations/descriptions of all malpractice claims made against you
- Completed Physician Assistant Authorization and Release (form in packet)
- Completed Arkansas Medical Practices Acts and Rules and Regulations Affidavit (form in packet)
- Completed Secondary Contact Designation (form in packet)
- Curriculum Vitae (CV)
- Copy of Driver's License or Passport
- Copies of all previous and current Federal DEA registration cards and state-issued controlled substance registration cards
- Copy of name change documents, if applicable
- Copy of proof of citizenship, naturalization, visa, or work permit, if applicable (*if not born in the U.S.*)
- Copy of DD Form 214 (Certificate of Release or Discharge from Active Duty), if you have served in any branch of the U.S. Armed Forces at any time during or since Medical School

You are required to request the following documents from their primary sources, and these documents must be sent from the primary source DIRECTLY to the Arkansas State Medical Board:

- Verification of Undergraduate Education and Official Transcript** (form in packet)
Complete Parts I and II, sign and then send a copy to the Dean or Registrar of each college, university, or technical school you attended.
- Verification of Physician Assistant Education and Official Transcript** (form in packet)
Complete Parts I and II, sign and then send a copy to the Dean or Registrar of each Physician Assistant school you attended.
- NCCPA PANCE Results/Eligibility**
Go to <http://www.nccpa.net/pdfs/information%20release%20form.pdf> to complete the NCCPA Request and Authorization for Release of Information form. If you have taken and passed the exam, request the Exam Results be sent. If you have not taken the exam, request the Eligibility Letter be sent.

- Verification of Licensure** (form in packet)
The applicant is no longer required to request verification of their out-of-state Physician Assistant licenses, except for those states that do not provide free, online verification through their website (MS, MA, NJ and ND, for example). In these states, the applicant will be required to request verification and pay any required fees. If any verifying source charges a fee for verification, does not offer online verification, or if their website has not been updated, the applicant is responsible for requesting verification and paying any fees. Complete Parts I and II of the form, sign and then send a copy to the licensing board.
- Verification of Hospital/Clinic Physician Assistant Affiliation** (form in packet)
Complete Parts I and II, sign and then send to the Medical Staff Office or Administration Office of every hospital and every clinic that granted you Physician Assistant privileges or employed you as a Physician Assistant.
Locum Tenens: Verification from each assignment facility is no longer required, as long as the locum tenens contract firm can provide a list of all of the applicant's assignments with exact dates.
- Professional Liability Verification** (form in packet)
The ASMB does NOT require applicants to have malpractice insurance prior to licensure. However, if you do carry malpractice insurance, send this form to every insurance company that currently insures you against malpractice claims. The completed form may be returned to ASMB by fax.
- Malpractice Claims Documents**
Court documents are no longer required for malpractice cases. If the case is settled, the NPDB report will suffice. However, the applicant will still be required to submit a signed narrative of the case as well as having the attorney send a narrative of the case, or have the insurance company send a claims history report.
- Verification of Military Service** (form in packet)
If you are active duty or in the reserves, complete the top portion of the form and then send with a copy of the Physician Assistant Authorization & Release form (also in this packet) to your Commanding Officer at your current duty station. If you are inactive military, you only need to provide a copy of your DD Form 214.
- Supervising Physician Application** (form in packet)
Send to your Supervising Physician for completion.
- Back-Up Supervising Physician Application** (form included in packet)
Send to your Back-up Supervising Physician for completion.
- Physician/Professional Reference/Recommendation Letter**
Only one (1) letter of recommendation is required. It cannot be from a physician who will be your supervising physician in Arkansas. To assure timely processing of your application, please communicate the following guidelines for submitting recommendation letters to the Board:
 - Letter must be written or 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 legible.
 - Letter must be addressed to the Arkansas State Medical Board and be mailed directly to the Board, stating that they are recommending you for licensure in Arkansas.
 - Letter must include your full, legal name. If an alternate name, nickname or the English translation is used, your full, legal name must still be referenced somewhere in the letter.
 - Letter must have personal comments about the applicant.
 - Letter must indicate whether or not they have worked with the applicant and state the work experience with the applicant regarding his or her knowledge base.
 - Letter must indicate their observation of the applicant's integrity or character.

INSTRUCTIONS FOR COMPLETING LICENSURE APPLICATION

READ CAREFULLY!

Question 1: Your name

- Enter your legal name as listed on your driver's license. If your name has changed due to marriage, divorce, adoption or naturalization, submit a notarized copy of pertinent document.
- Enter any other names used during your education or career, such as maiden name, nicknames, etc.

Question 2: Your identification

- Enter your social security number.
- Enter your driver's license number. *Send a copy of your driver's license with your license application.*
- Check male or female.
- Enter your date of birth (mm/dd/yyyy).

Question 3: Birthplace/Citizenship

- Enter the city and state (or city and country) where you were born.
- Enter the name of the country of which you are a citizen. *If you are a U.S. citizen but you were born in a foreign country, send a copy of your proof of citizenship.*
- If you are not a U.S. citizen, enter your immigration status. *Send a copy of your current Visa or Work Permit.* If you are a U.S. citizen, enter "n/a".
- If you are not a U.S. citizen, enter the number of years and/or months that you have lived in the U.S. If you are a U.S. citizen, enter "n/a".

Question 4: Your contact information

- Enter your current residence address. This is your home address for use by the Arkansas State Medical Board ONLY. It is NOT available to the public under the Freedom of Information Act (FOI) UNLESS you also use this address as your mailing, directory, or renewal address.
- Enter the address you wish to use as your "Directory" address. This is the address that will appear on the ASMB website's Online Directory, and is available to the public under FOI.
- Enter your current mailing address. This address appears on all printed reports and bulk data listings, including the free, online license verification, and is available to the public under FOI, and to credentialing organizations utilizing the ASMB website for license verification.
- Enter the address to which you wish to have your annual renewal packet mailed. While it is NOT published on our website or included in any of our standard reports or documents available to the public, it is considered public under FOI, and may be accessible to anyone requesting the opportunity to view documents in your file under FOI.
- e-h. Enter your home, work, fax, and mobile phone numbers in the appropriate spaces.
- i. Enter your e-mail address.

Question 5: Intended Practice Location

- Enter the name of the hospital, clinic, group or private practice where you will be practicing.
- Enter the mailing address of the hospital, clinic, group or private practice where you will be practicing.
- Enter the name of the physician that will be your Supervising Physician. If you have not found employment at the time of application, enter "pending."
- Enter your Supervising Physician's specialty. Please note that, per Regulation 24(5)(D), *"The supervising physician and back-up supervising physician must be skilled and trained in the same scope of practice as the tasks that have been assigned to and will be performed by the Physician Assistant that they supervise."*
- Enter the name of the physician that will be your Back-up Supervising Physician.
- Enter your Back-up Supervising Physician's specialty.

Question 6: Undergraduate Education

- Enter the full name of the college or university where you completed your undergraduate education. The application has space for two different schools in case you transferred. If you attended more than two schools, additional sheets may be attached. *Complete the top portion of the "Verification of Undergraduate Education" form contained in the application packet, and send one to each college or university you attended. Forms must be returned directly to this office from the institution.*
- Enter the mailing address of the college or university.
- Enter the date you started attending the college or university.
- Enter the date you left the college or university (graduated or left before completion).
- Answer "Yes" if you graduated, "No" if you did not graduate.
- Enter the degree you were awarded, or list the reason why you did not graduate (transferred schools, extended leave of absence, etc.). *If you did not graduate, you must submit a separate, signed and dated explanation of the circumstances.*

Question 7: Physician Assistant Education

- Enter the full name of the college or university program where you completed your Physician Assistant education. The application has space for two different programs in case you transferred. If you attended more than two programs, additional sheets may be attached. *Complete the top portion of the "Verification of Physician Assistant Education" form contained in the application packet, and send one to each Physician Assistant program you attended. Verifications must be returned directly from the institution to this office.*
- Enter the mailing address of the program.
- Enter the date you started attending the program.

- d. Enter the date you left the program (graduated or left before completion).
- e. Answer "Yes" if you graduated, "No" if you did not graduate.
- f. Enter the degree you were awarded, or list the reason why you did not graduate (transferred schools, extended leave of absence, etc.). *If you did not graduate, you must submit a separate, signed and dated explanation of the circumstances.*

Question 8: Examination

Answer "Yes" if you have passed the PANCE, "No" if you have not. *Go to the NCCPA website, <http://www.nccpa.net/pdfs/information%20release%20form.pdf> and complete the "Request and Authorization & Release of Information" form. If you have taken and passed the exam, request the "Exam Results" be sent directly to this office. If you have not taken and passed the exam, request the "Eligibility Letter" be sent directly to this office.*

Question 9: Licenses

- a. If you have never held a Physician Assistant license (including temporary or training permit) in another state or country, enter "None" in the first space and proceed to Question 10. If you have held a Physician Assistant license in another state or country, enter the name of that state or country here. The application has space for four licenses; if you have held more than four, additional sheets may be attached.
- b. Enter your Physician Assistant license number.
- c. Enter the date the Physician Assistant license was originally issued.
- d. Enter the date the Physician Assistant license expired or will expire.
- e. Enter "Yes" if this license is still active, "No" if it is not.

Question 10: Federal DEA Registration

- a. If you have never been licensed as a Physician Assistant, enter "n/a" in this space and proceed to question 11. If you have held a Physician Assistant license in another state and were registered with the DEA while you were in that state, enter the registration number here. If you have previously held more than one DEA registration, additional sheets may be attached. *Send a copy of your current DEA certificate(s).*
- b. Enter your address as listed on your DEA certificate. *Don't forget to notify the DEA of any address changes.*
- c. Enter the expiration date of your DEA registration.
- d. Enter "Yes" if this registration is active, "No" if it is not.

Question 11: Malpractice Insurance

- a. If you do not currently have professional liability (malpractice) insurance, enter "Pending" or "None at this time," and proceed to Question 12. If you do have malpractice insurance, enter the policy number. *Complete the top portion of the "Verification of Professional Liability Insurance" form included in the application packet, and send it to your insurance carrier.*
- b. Enter the name of your insurance carrier.

- c. Enter the expiration date of the policy.
- d. Enter the coverage limits.

Question 12: Military Service

- a. Answer "Yes" if you've ever served in the armed forces of the U.S. or any other country during or since Physician Assistant school. Answer "No" if you have not. *If yes, send a copy of your separation papers (DD Form 214) with your application. If Active Duty or Reserves, complete the top portion of the "Verification of Military Service" and send it to the Commanding Officer at your current duty station. Verifications must be returned directly from the source to this office.*
- b. Enter the country and branch you served.
- c. Enter the date you entered the armed forces.
- d. Enter the date you were discharged from the military.
- e. Enter the type of discharge you received (Honorable, General, etc.)

Question 13: Work History

- a. The application has enough space for 10 work history entries; if you need more space, additional sheets may be attached. You must enter all professional activities since the beginning of Physician Assistant school. Do NOT enter "See CV;" you must complete this section even though you are attaching your curriculum vitae. If you ever took a leave of absence of more than 30 days from this employer, or if there was a gap of 30 days or more between the end of your last activity and the beginning of this one, you must provide a separate, signed and dated explanation for the time gap. *Complete the top portion of the "Verification of Hospital/Clinic Physician Assistant Affiliation" and send one to the appropriate department at each hospital, clinic, group or private practice where you worked as a Physician Assistant. Verifications must be returned directly from the source to this office.*
- b. Enter the mailing address of the employer. *If the facility is closed, enter the last known address.*
- c. Enter the date your employment began.
- d. Enter the date your employment ended.
- e. Enter your title or position with this employer.
- f. Enter your current status with this employer (Active or Inactive)

Question 14: Physician/Professional Reference

- a. Enter the name of one (1) physician/professional reference (not related to you). This reference must have worked with you and directly observed your work performance in the recent past. This reference cannot be the physician who will be your Supervising Physician in Arkansas. *Have this reference provide a letter of recommendation for you. The recommendation letter must be sent directly from the reference to this office.*
- b. Enter how this person is associated with you (instructor, program director, etc.).
- c. Enter the mailing address (including the organization they are with) for this reference.

QUESTIONS 15-26 (ATTESTATION QUESTIONS):

For each "YES" response to questions 15 through 26, you must provide a separate, signed and dated statement giving full details, including date, location, type of action, organization or parties involved, and specific circumstances. If you are not sure how to respond to a question, it is best to disclose all information and provide an explanation. Failure to answer these questions accurately may result in disciplinary action or denial of license application.

FOR QUESTION 15, you must attach copy of original indictment, judgment or conviction, indicate whether paroled or placed on probation, and how probation was completed. If you have or had a record that was sealed, expunged or pardoned, you are still required to answer "Yes" to this question.

Affidavit of Applicant (Signature Page):

Read the affidavit completely before signing. Attach a recent photograph in the space shown. You must sign where indicated **IN THE PRESENCE OF A NOTARY PUBLIC**, swearing you are the person referred to in the application and that all statements contained therein are true and correct. The Notary seal should be affixed partially on the photograph. *Applications received without a photo or the required Notary seal will be returned to the applicant for completion, thereby delaying the application process.*



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Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org

Julia Feazell, P.A. Licensing Coordinator, (501) 296-1955, jdf@armedicalboard.org

APPLICATION FOR PHYSICIAN ASSISTANT LICENSURE IN ARKANSAS

1. Please read the IMPORTANT INFORMATION and ALL INSTRUCTIONS included in the application packet.
2. Type or print legibly (in dark blue or black ink) all application documents.
3. Provide exact dates whenever possible, in *mm/dd/yyyy* format.
4. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.
5. Give careful thought to each question before answering; remember, you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in Parts IV or V of the application, you MUST submit a signed and dated explanation.
7. Failure to answer all questions completely and accurately, or the omission or falsification of information, may be cause for denial of your application or disciplinary action if you are subsequently granted a license. **WHEN IN DOUBT, DISCLOSE AND EXPLAIN ALL INFORMATION.**

PART I - PERSONAL IDENTIFICATION INFORMATION

1a. Full Legal Name (Last, First, Middle, Suffix, Degree)			
1b. Other Names Used (including Maiden Name)			
2a. Social Security Number	2b. Driver's License State & Number	2c. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	2d. Date of Birth (mm/dd/yyyy) / /
3a. Place of Birth (City and State/Country)		3b. Country of Citizenship	
3c. Immigration Status (if not U.S. citizen)		3d. How long have you been in the U.S.? (if not U.S. citizen)	
4a. Residence Address (Street, City, State, Zip Code)			
4b. Directory Address (Street, City, State, Zip Code)			
4c. Mailing Address (PO Box or Street, City, State, Zip Code)			
4d. Renewal Address (Street, City, State, Zip Code)			
4e. Home Phone #	4f. Work Phone #	4g. Fax #	4h. Mobile Phone #
4i. E-mail Address			
5a. Intended Practice Location in Arkansas: Full Name Hospital, Clinic, Group or Private Practice			
5b. Mailing Address of Intended Practice Location (PO Box or Street, City, State, Zip Code)			
5c. Name of Supervising Physician		5d. Supervising Physician's Specialty	
5e. Name of Back-up Supervising Physician		5f. Back-up Supervising Physician's Specialty	

PART II - EDUCATION**UNDERGRADUATE EDUCATION**

List in chronological order all colleges, universities and technical schools you attended (attach additional sheets if necessary). Have each school complete and mail Verification of Undergraduate Education form directly to this office.

6a. Full Name of Institution

6b. Mailing Address (Street Address, City, State, Zip Code)

6c. Start Date

/ /

6d. End Date

/ /

6e. Graduated?

 Yes No

6f. Degree Awarded, or reason why you did not graduate

6a. Full Name of Institution

6b. Mailing Address (Street Address, City, State, Zip Code)

6c. Start Date

/ /

6d. End Date

/ /

6e. Graduated?

 Yes No

6f. Degree Awarded, or reason why you did not graduate

PHYSICIAN ASSISTANT PROGRAM

List in chronological order all Physician Assistant Programs you attended (attach additional sheets if necessary). Have each school complete and mail Verification of Physician Assistant Education form directly to this office.

7a. Full Name of Institution and Program

7b. Mailing Address (Street Address, City, State, Zip Code)

7c. Start Date

/ /

7d. End Date

/ /

7e. Graduated?

 Yes No

7f. Degree Awarded, or reason why you did not graduate

7a. Full Name of Institution and Program

7b. Mailing Address (Street Address, City, State, Zip Code)

7c. Start Date

/ /

7d. End Date

/ /

7e. Graduated?

 Yes No

7f. Degree Awarded, or reason why you did not graduate

EXAMINATION HISTORY8. Have you passed the PANCE? Yes No

If Yes, have certification from NCCPA mailed directly to this office.
If No, have eligibility confirmation from NCCPA mailed directly to this office.

PART III - PROFESSIONAL**PROFESSIONAL LICENSURE**

List all states or territories of the United States, provinces of Canada, or other countries in which you hold or have ever held a Physician Assistant license. Attach additional sheets if necessary.

9a. Jurisdiction (State, Country)

9b. License No.

9c. Issue Date

/ /

9d. Expiration Date

/ /

9e. Active? (Yes/No)

9a. Jurisdiction (State, Country)

9b. License No.

9c. Issue Date

/ /

9d. Expiration Date

/ /

9e. Active? (Yes/No)

9a. Jurisdiction (State, Country)

9b. License No.

9c. Issue Date

/ /

9d. Expiration Date

/ /

9e. Active? (Yes/No)

9a. Jurisdiction (State, Country)

9b. License No.

9c. Issue Date

/ /

9d. Expiration Date

/ /

9e. Active? (Yes/No)

FEDERAL DEA REGISTRATION

If you have a Federal DEA registration as a Physician Assistant in another state, complete the following and submit a copy of your Federal DEA Registration card with your application. If you have never held a Federal DEA registration, enter "n/a."

10a. Federal DEA Registration #

10b. Your address associated with this registration

10c. Expiration Date

/ /

10d. Active? (Yes/No)

**PROFESSIONAL LIABILITY
(MALPRACTICE) INSURANCE**

If you have malpractice insurance, complete the following and submit a copy of your Certificate of Insurance. If you do not have malpractice insurance, enter "n/a" or "None."

11a. Policy Number	11b. Insurance Carrier Name	11c. Expiration Date / /	11d. Coverage Limits
--------------------	-----------------------------	-----------------------------	----------------------

MILITARY SERVICE

Submit a copy of your separation papers (DD Form 214) with your application. If you are currently Active Duty or Reserves, have your Commanding Officer complete the Verification of Military Service and send it directly to this office.

12a. Have you ever been in the armed forces? Yes No *If yes, complete questions 12b-12e.*

12b. Country & Branch of Service	12c. Date of Entry / /	12d. Date of Discharge / /	12e. Type of Discharge
----------------------------------	---------------------------	-------------------------------	------------------------

WORK HISTORY

Please provide a chronological listing of all activities, institutional affiliations or places of employment since the beginning of Physician Assistant school. This includes hospitals, teaching appointments, HMOs, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. You must provide explanations of any time gaps and leaves of absence of more than 30 days since the beginning of Physician Assistant school. **Do not write, "See CV;" you must complete this section even though you are attaching your curriculum vitae.** Have each facility/entity complete and mail Verification of Hospital/Clinic Affiliation form or letter directly to this office.

13a. Name of Institution/Facility/Employer

13b. Mailing Address (Street or PO Box, City, State, Zip Code)

13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
-----------------------	---------------------	---------------------	-------------

13a. Name of Institution/Facility/Employer

13b. Mailing Address (Street or PO Box, City, State, Zip Code)

13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
-----------------------	---------------------	---------------------	-------------

13a. Name of Institution/Facility/Employer

13b. Mailing Address (Street or PO Box, City, State, Zip Code)

13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
-----------------------	---------------------	---------------------	-------------

13a. Name of Institution/Facility/Employer

13b. Mailing Address (Street or PO Box, City, State, Zip Code)

13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
-----------------------	---------------------	---------------------	-------------

13a. Name of Institution/Facility/Employer

13b. Mailing Address (Street or PO Box, City, State, Zip Code)

13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
-----------------------	---------------------	---------------------	-------------

13a. Name of Institution/Facility/Employer

13b. Mailing Address (Street or PO Box, City, State, Zip Code)

13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
-----------------------	---------------------	---------------------	-------------

WORK HISTORY, continued			
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
PHYSICIAN/PROFESSIONAL REFERENCE		Have one (1) physician/professional with whom you have worked as a Physician Assistant mail a letter of recommendation directly to this office. This reference cannot be your Supervising Physician for Arkansas.	
14a. Name		14b. Association	
14c. Mailing Address (Organization, Street or PO Box, City, State, Zip Code)			

CONTINUE TO PAGE 5

PART IV - ATTESTATION QUESTIONS

SPECIAL INSTRUCTIONS FOR QUESTIONS 15-26

- Please mark the appropriate box next to each question. Do not leave any questions blank.
- For each "Yes" response to questions 15-26, you must provide a separate, signed and dated statement giving full details including date, location, type of action, organization or parties involved, and specific circumstances. **If you are not sure about how to respond to a question, it is best to disclose all information and provide an explanation.**
- Failure to answer these questions accurately may result in disciplinary action or denial of license application.
- Confidentiality: The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.

15. Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony? (NOTE: You must answer "Yes" even if records, charges, or convictions have been pardoned, expunged, plead down, released, or sealed.) *If yes, explain.* No Yes
16. Do you have any physical, mental or emotional impairment? *If yes, explain.* No Yes
17. Have you ever been addicted to alcohol or drugs? *If yes, explain.* No Yes
18. Have you ever had a DWI or DUI? How many? _____ *If yes, explain.* No Yes
19. Have you ever been treated for alcohol/substance abuse in a treatment center or hospital? *If yes, give name of institution, date and length of stay in your explanation.* No Yes
20. Has any medical licensing board ever placed your license on probation, suspension, or has it revoked a license or certificate granted to you? *If yes, list name and address of board in your explanation.* No Yes
21. Have you ever been ordered to appear before a state medical board for any reason other than licensure? *If yes, explain.* No Yes
22. Have disciplinary procedures ever been initiated toward you by either a Medical Board or Hospital? *If yes, give name and address of board or hospital in your explanation.* No Yes
23. Have you ever voluntarily surrendered your license in any other state? *If yes, give name and address of board in your explanation.* No Yes
24. Have you ever previously made application to the Arkansas State Medical Board? *If yes, explain.* No Yes
25. Have any malpractice claims been filed against you? *If yes, provide official documentation from your attorney or insurance company.* No Yes
26. 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.* No Yes

continue to next page

PART V - AFFIDAVIT OF APPLICANT

I, _____, hereby certify, after being duly sworn, that I have read the complete application and know the full content thereof. I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true, correct, current, and complete to the best of my knowledge. I certify that the photograph that appears below is a true likeness of me, taken within the past sixty (60) days. I understand that any falsification or misrepresentation of any item or response in this application, or any documentation supporting this application, even if submitted separately, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice as a Physician Assistant in the State of Arkansas.

AFFIX
PASSPORT-STYLE
PHOTOGRAPH
HERE

Applicant's Signature (in ink)

(must be signed in the presence of a Notary Public)

Date Signed

(must include the month, day and year signed)

.....
SUBSCRIBED AND SWORN TO before me, a Notary Public in and
for the State of _____, this
_____ day of _____, 20 _____.
(Notary date must be the same as the applicant's signature date above)

My commission expires: _____

Notary Signature

(Notary seal must overlie a portion of the photograph at left)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

APPLICATION RECEIVED: ____ / ____ / ____ FEE RECEIVED: \$ _____ DATE: ____ / ____ / ____

TEMPORARY LICENSE #: _____ TEMP ISSUED: ____ / ____ / ____ TEMP EXPIRES: ____ / ____ / ____

PHYSICIAN ASSISTANT LICENSE #: _____ FULL LICENSE ISSUED: ____ / ____ / ____

APPROVAL SIGNATURE: _____ SIGNATURE DATE: _____



ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 www.armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

Physician Assistant

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE 17-105-101, *et seq.*, AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD.

Physician Assistant's Full Name (First Middle Last, Suffix, Degree)

Physician Assistant's Signature (no rubber stamps)

Signature Date

**THIS IS A REQUIREMENT FOR LICENSURE.
YOUR LICENSURE APPLICATION WILL NOT BE PROCESSED
WITHOUT THIS COMPLETED FORM.**



ARKANSAS STATE MEDICAL BOARD

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AUTHORIZATION AND RELEASE PHYSICIAN ASSISTANT

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, on staff, or associated; any employees of any malpractice insurance carriers; any state medical licensing boards where I have been licensed or have applied for a license; any medical clinics where I have been employed or associated; and any 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, and/or evaluations of my performances.

I hereby release and discharge you 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 information furnished to the Arkansas State Medical Board.

A copy of this Authorization and Release may be provided to each individual, hospital or organization where information concerning my credentials is sought and this Authorization and Release shall remain in effect until specifically revoked by me in writing.

Typed or Printed Name of Physician Assistant: _____

Social Security Number: _____

Signature of Physician Assistant: _____
Dark Blue or Black Ink Only - No Signature Stamps

Signature Date: _____



ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

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Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org

SECONDARY CONTACT DESIGNATION FORM

So that the licensing process might be made easier for both you and the Board, your Licensing Coordinator will communicate with you and ONE other person of your choice regarding the status of your licensure application. However, please advise your designated contact that your Licensing Coordinator is working with several applicants at any given time, and that repeated phone calls to check on the status of your application will only delay the processing time for all applicants. We appreciate your consideration of this.

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

Print full name of Secondary Contact

Organization Name

Email address of Secondary Contact

Phone number of Secondary Contact

Print full name of Applicant

Signature of Applicant (no signature stamps)

Date Signed

This document must be completed and returned with your initial application. Information regarding your licensure application will not be released to anyone other than you without this written authorization.



ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 www.armedicalboard.org

PHYSICIAN ASSISTANT SUPERVISING PHYSICIAN APPLICATION

1. This form is to be filled out by the prospective Supervising Physician.
2. Type or print legibly (in dark blue or black ink).
3. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.

PHYSICIAN ASSISTANT

Physician Assistant's Name

SUPERVISING PHYSICIAN INFORMATION

Supervising Physician's Name			License Number
Complete Address (PO Box or Street, City, State, Zip Code)			
Office Telephone Number	Office Fax Number	Home Telephone Number	Cellular Telephone #
E-mail Address	Specialty	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type or Scope of Practice			
Services Rendered			
Area or Geographic Range of Practice			
Type of Facility <input type="checkbox"/> Private Practice <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Other _____			

BACK-UP SUPERVISING PHYSICIAN(S) INFORMATION (attach additional sheets if necessary)

Back-up Supervising Physician #1	Medical License Number
Complete Address (PO Box or Street, City, State, Zip Code)	
When will Back-up Supervising Physician be utilized?	
Back-up Supervising Physician #2	Medical License Number
Complete Address (PO Box or Street, City, State, Zip Code)	
When will Back-up Supervising Physician be utilized?	

Continue to next page

PHYSICIAN ASSISTANTS CURRENTLY UNDER YOUR SUPERVISION

Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising Physician <input type="checkbox"/> Back-up	P.A. License Number
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising Physician <input type="checkbox"/> Back-up	P.A. License Number
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising Physician <input type="checkbox"/> Back-up	P.A. License Number

IMPORTANT INFORMATION**THE FOLLOWING ITEMS MUST BE INCLUDED WHEN SUBMITTING THIS APPLICATION.**

1. Payment in the amount of \$50.00, to be paid by the Supervising Physician. Make check payable to ASMB.
2. Arkansas Medical Practices Act and Rules and Regulations Affidavit, signed by Supervising Physician.
3. Copy of Supervising Physician's Federal DEA registration certificate.
4. Copy of Supervising Physician's current professional liability insurance certificate.
5. Signed protocol.

Not sending these items together will result in a delay of the application process.

Supervising Physician's Signature
(must be signed in the presence of a Notary Public)

Date Signed

SUBSCRIBED AND SWORN to before me, a Notary Public in and for the State of _____,

this _____ day of _____, 20_____.

My commission expires: _____

Notary Signature

(Notary Seal)

FOR OFFICE USE ONLY

Application Received Date: _____

Fee Received: \$ _____

Date Approved: _____

Fee Received Date: _____



ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

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ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

(Supervising Physician)

I AFFIRM THAT I HAVE READ THE PHYSICIAN ASSISTANT ACT, ARKANSAS CODE 17-105-101, *et seq.*, AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD. I UNDERSTAND THAT I TAKE FULL RESPONSIBILITY FOR THE ACTIONS OF _____ WHILE HE/SHE IS UNDER MY SUPERVISION.

Supervising Physician's Full Name (First Middle Last, Suffix, Degree)

Supervising Physician's Signature (no rubber stamps)

Signature Date

**THIS IS A REQUIREMENT FOR LICENSURE.
YOU MUST COMPLETE THIS FORM AND RETURN IT TO:**

**ARKANSAS STATE MEDICAL BOARD
ATTN: P.A. LICENSING COORDINATOR
1401 W CAPITOL AVE, SUITE 340
LITTLE ROCK, AR 72201**

(Facility Letterhead)
(Today's Date)

In compliance with statute 17-105-101, a copy of this agreement will be kept on file at all Arkansas practice sites and with the Arkansas State Medical Board. This agreement will go into effect *(list date here)*. It will be updated as necessary to reflect changes in the practice.

Physician Assistant Protocol and Delegation of Services Agreement for *(Name of P.A.)*

Name of Facility
Address of Facility
Phone Number of Facility
Fax Number of Facility

List all locations P.A. will work

Supervising Physician: _____ **License #:** _____

***Back-up Supervising Physician:** _____ **License #:** _____

* Add additional lines if needed

Services to be performed by Physician Assistant in the medical practice of the above-referenced physicians: (be specific in your list as indicated in the example below)

- ◆ Obtain chief complaint
- ◆ Obtain history
- ◆ Perform physical
- ◆ Order lab tests
- ◆ Develop problem list
- ◆ Formulate and institute care plan
- ◆ Patient education
- ◆ Patient follow-up
- ◆ Hospital rounds

List ONLY the Services and Procedures that you actually perform

Procedures to be performed by Physician Assistant in the medical practice of the above-referenced physicians: (be specific in your list as indicated in the example below)

- ◆ Start IVs
- ◆ Venipunctures
- ◆ Suture simple wounds (no tendon, vascular, nerve injuries)
- ◆ Medication injections (specify class of drugs and where administered (IM; IA; subcutaneous))
- ◆ Application of splints
- ◆ Incision and drainage of superficial abscesses such as infected sebaceous cysts
- ◆ Nasogastric tube placement
- ◆ Placement of urinary catheter
- ◆ Wound debridement and dressing changes
- ◆ Anoscopy
- ◆ Pap smears
- ◆ Joint injections/aspirations (specify location, i.e., elbow, wrist, knee, etc.)

Procedures requiring on-site physician supervision: (be specific in your list)

◆

Medications to be prescribed by the Physician Assistant: (pending DEA and ASMB approval; be specific in your list as indicated in the example below)

- ◆ All non-controlled medications with the following exceptions:
 - Chemotherapeutic agents
 - Immunosuppressive agents with the exception of steroids
 - Thrombolytic agents
- ◆ Controlled medications within Schedules III, IV, V

Type and frequency of supervision by the Supervising Physician:

The Physician Assistant’s delegated scope of practice has the following restrictions: activities in which diagnosis, treatment or management exceeds the Physician Assistant’s level of competence, training or skill or is outside the scope of the physician’s level.

The Supervising Physician or his Back-up Supervising Physician will be on-site or available at all times to the Physician Assistant. One of these physicians will be within a driving radius of 60 minutes of the Physician Assistant and would always be available by phone.

The Physician Assistant will not practice if the Supervising Physician and/or the Back-up Supervising Physician is physically absent, not physically available within 60 minutes, or available by phone.

Process of Evaluation by Supervising Physician and Back-up Supervising Physician:

- ◆ 100% review and countersign the documentation of all Physician Assistant patient encounters within the first 120 days of employment
- ◆ Following the first 120 days of employment, the Supervising Physician will review and countersign a minimum of 10% (or more as specified in the protocol) of all Physician Assistant patient encounters in the clinic setting
- ◆ 100% review and countersign of all inpatient Physician Assistant patient encounters in compliance with the bylaws and rules and regulations of *(name of facility)*
- ◆ 100% review of all procedures performed by the Physician Assistant within the first 120 days of employment

Local ambulance service will be used to transport medical emergencies when Supervising Physician or Back-up Supervising Physician is not on-site. Progress notes written by the Physician Assistant for patients who require hospital admission or transfer to the emergency department of the local hospital will be countersigned by the Supervising Physician within 24 hours.

The Physician Assistant may be allowed to make hospital rounds at *(name of facility)*.

Printed Name of PA: _____

Signature of PA: _____ **Date:** _____

Printed Name of Supervising Physician: _____

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

Printed Name of Back-Up Supervising Physician: _____

Signature of Back-Up Supervising Physician: _____ **Date:** _____

(Add additional lines for additional Back-Up Supervising Physicians)

Arkansas State Medical Board:

Signature: _____ **Date:** _____
Chairman, Physician Assistant Advisory Committee

Board Seal:



ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 www.armedicalboard.org

PHYSICIAN ASSISTANT BACK-UP SUPERVISING PHYSICIAN APPLICATION

1. This form is to be filled out by the prospective Back-Up Supervising Physician.
2. Type or print legibly (in dark blue or black ink).
3. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.

PHYSICIAN ASSISTANT

Physician Assistant's Name

BACK-UP SUPERVISING PHYSICIAN INFORMATION

Back-up Supervising Physician's Name	Medical License Number
--------------------------------------	------------------------

Complete Address (PO Box or Street, City, State, Zip Code)

Office Telephone Number	Office Fax Number	Home Telephone Number	Cellular Telephone #
-------------------------	-------------------	-----------------------	----------------------

E-mail Address	Specialty	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
----------------	-----------	--

Type or Scope of Practice

Services Rendered

Area or Geographic Range of Practice

Type of Facility
 Private Practice Clinic Hospital Other _____

PRIMARY SUPERVISING PHYSICIAN(S) INFORMATION

Primary Supervising Physician	Medical License Number
-------------------------------	------------------------

Complete Address (PO Box or Street, City, State, Zip Code)

PHYSICIAN ASSISTANTS CURRENTLY UNDER YOUR SUPERVISION

Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. License Number
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. License Number
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. License Number

Continue to next page

IMPORTANT INFORMATION

THE FOLLOWING ITEMS MUST BE INCLUDED WHEN SUBMITTING THIS APPLICATION.

- 1. Signed Arkansas Medical Practices Act and Rules & Regulations Affidavit**
- 2. Signed Back-Up Supervising Physician Scope of Practice Statement**
- 3. Signed protocol**

Not sending these items together will result in a delay of the application process.

Supervising Physician's Signature
(does not require Notary)

Date Signed

Back-up Supervising Physician's Signature
(must be signed in the presence of a Notary Public)

Date Signed

SUBSCRIBED AND SWORN to before me, a Notary Public in and for the State of _____,

this _____ day of _____, 20_____.

My commission expires: _____

Notary Signature

(Notary Seal)

FOR OFFICE USE ONLY

Application Received Date: _____

Fee Received: \$ _____

Date Approved: _____

Fee Received Date: _____



ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 www.armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

(Back-up Supervising Physician)

I AFFIRM THAT I HAVE READ THE PHYSICIAN ASSISTANT ACT, ARKANSAS CODE 17-105-101, *et seq.*, AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD. I UNDERSTAND THAT I TAKE FULL RESPONSIBILITY FOR THE ACTIONS OF _____ WHILE HE/SHE IS UNDER MY SUPERVISION.

Back-Up Supervising Physician's Full Name (First Middle Last, Suffix, Degree)

Back-Up Supervising Physician's Signature (no rubber stamps)

Signature Date

**THIS IS A REQUIREMENT FOR LICENSURE.
YOU MUST COMPLETE THIS FORM AND RETURN IT TO:**

**ARKANSAS STATE MEDICAL BOARD
ATTN: P.A. LICENSING COORDINATOR
1401 W CAPITOL AVE, SUITE 340
LITTLE ROCK, AR 72201**



ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 www.armedicalboard.org

BACK-UP SUPERVISING PHYSICIAN SCOPE OF PRACTICE STATEMENT

Regulation 24(5)(D) states:

The supervising physician and back-up supervising physician must be skilled and trained in the same scope of practice as the tasks that have been assigned to and will be performed by the Physician Assistant that they supervise.

I have reviewed the protocol of this Physician Assistant. My scope of practice and/or training is similar to the Supervising Physician and I feel that I can supervise this Physician Assistant in the absence of the Supervising Physician.

Back-Up Supervising Physician's Full Name (First Middle Last, Suffix, Degree)

Back-Up Supervising Physician's Signature (no rubber stamps)

Signature Date

Physician Assistant's Full Name

**THIS IS A REQUIREMENT FOR LICENSURE.
YOU MUST COMPLETE THIS FORM AND RETURN IT TO:**

**ARKANSAS STATE MEDICAL BOARD
ATTN: P.A. LICENSING COORDINATOR
1401 W CAPITOL AVE, SUITE 340
LITTLE ROCK, AR 72201**



ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org

PHYSICIAN ASSISTANT JURISPRUDENCE EXAM II

Name of Physician Assistant: _____ Date: _____

Answer each question "T" (true) or "F" (false).

1. _____ If a Physician Assistant violates the standards of medical practice as set forth in the Arkansas Medical Practices Act and Rules and Regulations of the Board, the Supervising Physician is liable and may have charges brought against him/her by the Arkansas State Medical Board.
2. _____ The Arkansas State Medical Board may discipline any Physician Assistant who is convicted of a felony.
3. _____ Prior to any changes in the Physician Assistant's protocol being enacted, they must be submitted to and approved by the Board.
4. _____ A Physician Assistant is only authorized to prescribe scheduled medications that are within the Supervising Physician's scope of practice.
5. _____ Failure to complete continuing education hours as required may result in the licensee having his/her license suspended and/or revoked.
6. _____ An applicant may be granted two (2) extensions of his/her graduate license while awaiting the results of his/her PANCE.
7. _____ A retired physician may practice as a Physician Assistant as long as he has a Supervising Physician.
8. _____ A temporary license may be granted to an applicant who meets all the qualifications for licensure but is awaiting the next scheduled meeting of the Board.
9. _____ Physician Assistants may prescribe, direct the use of, or use any optical device in connection with ocular exercises, vision training or orthoptics.
10. _____ It is a violation of the Physician Assistant Act for a Physician Assistant to represent him/herself as a physician.
11. _____ A Physician Assistant may receive payment from a patient or HMO for the services he/she renders.
12. _____ A Physician Assistant is not required to wear a nametag identifying him/herself as a Physician Assistant.
13. _____ An individual must be 18 years of age to be licensed as a Physician Assistant in Arkansas.
14. _____ Arkansas requires an annual license renewal for Physician Assistants.

15. _____ All Physician Assistants in Arkansas must be licensed with this Board, no matter where they are employed (excluding the Federal government).
16. _____ A Supervising Physician may delegate prescriptive authority to Physician Assistants, including prescribing, ordering and administering Schedule I through V controlled substances.
17. _____ Physician Assistants who prescribe controlled substances do not need to register with the Drug Enforcement Administration as long as his/her Supervising Physician is registered.
18. _____ A physician desiring to supervise a Physician Assistant must have an active Arkansas license.
19. _____ A Physician Assistant must notify the Board of any changes or additions in his/her Supervising Physician or protocol within thirty (30) calendar days.
20. _____ A Physician Assistant who holds an active license in the State of Arkansas shall complete twenty-five (25) credit hours of continuing medical education per year.
21. _____ Prescriptions written by a Physician Assistant must contain the name of the Supervising Physician on the prescription.
22. _____ Physician Assistants must send a copy of all prescriptions written to the Arkansas State Medical Board on a quarterly basis.



ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone: (501) 296-1802 Fax: (501) 296-1805 E-mail: support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF UNDERGRADUATE EDUCATION

PART I – INSTITUTION NAME AND MAILING ADDRESS

Institution Name: _____
 Department or Office: _____
 Address Line 1: _____
 Address Line 2: _____
 City, State, ZIP Code: _____

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy) / /
Other Names Used		Date of Graduation (mm/dd/yyyy) / /
<i>AUTHORIZATION & RELEASE: I hereby authorize the entity named above, 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 entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.</i>		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY DEAN, REGISTRAR or AUTHORIZED REPRESENTATIVE ONLY)

Please complete the information below (or your equivalent verification letter) and return **with an official transcript directly to the Arkansas State Medical Board**. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of College or University (if not correct above)		
Date Education Began / /	Date Education Ended / /	Degree Awarded (ex: B.S. in Biological Sciences) <input type="checkbox"/> None
If degree was not awarded, please provide explanation (use additional sheets if necessary)		
During this applicant's education, was he/she ever investigated or disciplined by the school for any reason? [Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted or otherwise disciplined. If you respond "Yes" to this question, please provide a detailed explanation on a separate sheet, signed and dated by the person whose signature appears below.]		
		<input type="checkbox"/> Yes <input type="checkbox"/> No

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name	Position/Title	
Phone Number	Fax Number	E-mail Address

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ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone: (501) 296-1802 Fax: (501) 296-1805 E-mail: support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF PHYSICIAN ASSISTANT EDUCATION

PART I – INSTITUTION NAME AND MAILING ADDRESS

Institution Name: _____

Department or Office: _____

Address Line 1: _____

Address Line 2: _____

City, State, ZIP Code: _____

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy) / /
Other Names Used		Date of Graduation (mm/dd/yyyy) / /
<i>AUTHORIZATION & RELEASE: I hereby authorize the entity named above, 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 entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.</i>		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY DEAN, REGISTRAR or AUTHORIZED REPRESENTATIVE ONLY)

Please complete the information below (or your equivalent verification letter) and return **with an official transcript directly to the Arkansas State Medical Board**. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Physician Assistant School (if not correct above)		
Date P.A. Education Began / /	Date P.A. Education Ended / /	Degree Awarded (ex: Master of Science in Physician Assistant Studies) <input type="checkbox"/> None
If program was not completed, or was completed in more or less than the customary time frame for such training, please provide explanation (use additional sheets if necessary)		
During this applicant's education, was he/she ever investigated or disciplined by the school for any reason? [Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted or otherwise disciplined. If you respond "Yes" to this question, please provide a detailed explanation on a separate sheet, signed and dated by the person whose signature appears below.] <input type="checkbox"/> Yes <input type="checkbox"/> No		

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name	Position/Title	
Phone Number	Fax Number	E-mail Address

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PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone: (501) 296-1802 Fax: (501) 296-1805 E-mail: support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF LICENSURE

PART I – LICENSING AUTHORITY NAME AND MAILING ADDRESS

Name of Licensing Authority: _____

ATTN: _____

Address Line 1: _____

Address Line 2: _____

City, State, ZIP Code: _____

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy) / /
Other Names Used		License Number for this state or country
<i>AUTHORIZATION & RELEASE: I hereby authorize the entity named above, 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 entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.</i>		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY LICENSING AUTHORITY STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

State/Country	Name of Licensing Authority (if not correct above)		
License Number	Original Issue Date (mm/dd/yyyy) / /	Expiration Date (mm/dd/yyyy) / /	
Current License Status <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Temporary <input type="checkbox"/> Other: _____			
License Category <input type="checkbox"/> Unlimited <input type="checkbox"/> Educational <input type="checkbox"/> Other: _____			
Please answer the following questions and attach explanations and dates for any "Yes" answers			
Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction, or is any such investigation pending?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction, or is any such action pending?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state, or is any such action pending?			<input type="checkbox"/> Yes <input type="checkbox"/> No

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name	Position/Title	
Phone Number	Fax Number	E-mail Address

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PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone: (501) 296-1802 Fax: (501) 296-1805 E-mail: support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF HOSPITAL/CLINIC PHYSICIAN ASSISTANT AFFILIATION

PART I – FACILITY NAME AND MAILING ADDRESS

Name of Facility: _____

ATTN: _____

Address Line 1: _____

Address Line 2: _____

City, State, ZIP Code: _____

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy) / /
Other Names Used		Date of Graduation (mm/dd/yyyy) / /
<i>AUTHORIZATION & RELEASE: I hereby authorize the entity named above, 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 entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.</i>		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY FACILITY AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Facility (if not correct above)		
Current Staff Status <input type="checkbox"/> Current <input type="checkbox"/> Inactive <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other _____		
Date Privileges Began (including temp or provisional) / /	Date Privileges Ended / /	<input type="checkbox"/> If exact dates are not available, please check here. If currently appointed, please write "Present" in the space for end date.
Note: Breaks in appointment should be listed as separate entries. If the applicant was there intermittently, a listing of each time period he/she was appointed to your facility's ancillary staff should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing appointment dates. Thank you.		
To the best of your knowledge, are/were the applicant's clinical privileges in good standing during the stated period of time? (if No, please attach detailed explanation)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Were the clinical privileges of this applicant ever denied, revoked, limited or suspended? (if Yes, please attach detailed explanation)		<input type="checkbox"/> Yes <input type="checkbox"/> No

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name	Position/Title	
Phone Number	Fax Number	E-mail Address

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ARKANSAS STATE MEDICAL BOARD

PHYSICIAN ASSISTANT LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone: (501) 296-1802 Fax: (501) 296-1805 E-mail: support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF PROFESSIONAL LIABILITY INSURANCE

PART I – INSURANCE CARRIER AND AGENCY NAME AND MAILING ADDRESS

Name of Insurance Carrier:

Name of Insurance Agency:

Address Line 1:

Address Line 2:

City, State, ZIP Code:

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy) / /
Policy Number	If Group Policy, name of Group	
<i>AUTHORIZATION & RELEASE: I hereby authorize the entity named above, 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 entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.</i>		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY INSURANCE CARRIER OR AGENCY STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Insurance Carrier	Name of Agency/Producer		
Agency/Producer Address (if not correct in address block above)			
Policy Number	Date Coverage Began / /	Date Coverage Ends / /	Retroactive Date / /
Coverage Type <input type="checkbox"/> Occurrence-based <input type="checkbox"/> Claims-based <input type="checkbox"/> Tail Coverage	Coverage Limits \$ _____ / \$ _____		
Have any specific procedures been excluded from this coverage? If yes, please list procedures.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your insurance company defended this provider in any professional liability suits?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your insurance company currently have any pending judgments or settlements on behalf of this provider?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your insurance company paid judgments or settlements on behalf of this provider?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If you answered "Yes" to any of the above questions, please provide both a claims history report AND 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, and the name and address of the attorney who defended this provider.</i>			

PART IV - VERIFIED BY

Verification provided by (Signature)	Signature Date / /	
Type or legibly print name	Position/Title	
Phone Number	Fax Number	E-mail Address

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ARKANSAS STATE MEDICAL BOARD



ARKANSAS MEDICAL PRACTICES ACTS & REGULATIONS FOR PHYSICIAN ASSISTANTS

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PHYSICIAN ASSISTANTS

17-105-101. Definitions.

As used in this chapter:

- (1) "Board" means the Arkansas State Medical Board;
- (2) (A) "Physician assistant" means a person who has:
 - (i) Graduated from a physician assistant or surgeon assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs; and
 - (ii) Passed the certifying examination administered by the National Commission on Certification of Physician Assistants.
- (B) The physician assistant is a dependent medical practitioner who:
 - (i) Provides health care services under the supervision of a physician; and
 - (ii) Works under a physician-drafted protocol approved by the Arkansas State Medical Board, which describes how the physician assistant and the physician will work together and any practice guidelines required by the supervising physician;
- (3) "Supervision" means overseeing the activities of and accepting responsibility for the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required so long as the supervising physician and physician assistant are or can be easily in contact with one another by radio, telephone, electronic, or other telecommunication device. Supervision of each physician assistant by a physician or physicians shall be continuous; and
- (4) "Supervising physician" means a doctor of medicine or doctor of osteopathy licensed by the board who supervises physician assistants.

History. Acts 1999, No. 851, § 1.

17-105-102. Qualifications for licensure.

- (a) Except as otherwise provided in this chapter, an individual must be licensed by the Arkansas State Medical Board before the individual may practice as a physician assistant.
- (b) The board may grant a license as a physician assistant to an applicant who:
 - (1) Submits an application on forms approved by the board;
 - (2) Pays the appropriate fees as determined by the board;
 - (3) Has successfully completed an educational program for physician assistants or surgeon assistants accredited by the Committee on Allied Health Education and Accreditation or by its successor agency and has passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants;
 - (4) Certifies that he or she is mentally and physically able to engage safely in practice as a physician assistant;
 - (5) Has no licensure, certification, or registration as a physician assistant under current discipline, revocation, suspension, or probation for cause resulting from the applicant's practice as a physician assistant, unless the board considers such condition and agrees to licensure;
 - (6) Is of good moral character;

- (7) Submits to the board any other information the board deems necessary to evaluate the applicant's qualifications;
- (8) Has been approved by the board;
- (9) Is at least twenty-one (21) years of age; and
- (10) After July 1, 1999, has at least a bachelor's degree in some field of study from a regionally accredited college or university, unless the applicant has:
 - (A) Prior service as a military corpsman and is a graduate of a physician assistant education program recognized by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs or the applicant is currently certified by the National Commission on Certification of Physician Assistants;
 - (B) Was serving as a physician assistant in a federal facility located in the State of Arkansas on or after July 1, 1999, and who is a graduate of a physician assistant education program recognized by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs;
 - (C) Was licensed in good standing on June 30, 1999, by the Arkansas State Medical Board; or
 - (D) Was enrolled on or before July 1, 1999, in a physician assistant program recognized by the Commission on Accreditation of Allied Health Education Programs.

History. Acts 1999, No. 851, § 2.

17-105-103. Graduate license — Temporary license.

- (a) The Arkansas State Medical Board may grant a graduate license to an applicant who meets the qualifications for licensure, except that the applicant has not yet taken the national certifying examination or the applicant has taken the national certifying examination and is awaiting the results.
- (b) A graduate license is valid:
 - (1) For one (1) year from the date of issuance;
 - (2) Until the results of an applicant's examination are available; or
 - (3) Until the board makes a final decision on the applicant's request for licensure, whichever comes first.
- (c) The board may extend a graduate license upon a majority vote of the board members for a period not to exceed one (1) year. Under no circumstances may the board grant more than one (1) extension of a graduate license.
- (d) A temporary license may be granted to an applicant who meets all the qualifications for licensure but is awaiting the next scheduled meeting of the board.

History. Acts 1999, No. 851, § 3.

17-105-104. Inactive license.

Any physician assistant who notifies the Arkansas State Medical Board in writing on forms prescribed by the board may elect to place his or her license on inactive status. A physician assistant with an inactive license shall be excused from payment of renewal fees and shall not practice as a physician assistant. Any licensee who engages in practice while his or her license is lapsed or on inactive status shall be considered to be practicing without a license, which shall be grounds for discipline under § 17-105-113. A physician assistant requesting restoration from inactive status shall be required to pay the current renewal fee and shall be required to meet the criteria for renewal as specified in § 17-105-105.

History. Acts 1999, No. 851, § 4.

17-105-105. Renewal.

Upon notification from the Arkansas State Medical Board, each person who holds a license as a physician assistant in this state shall renew the license by:

- (1) Submitting the appropriate fee as determined by the board;
- (2) Completing the appropriate forms; and
- (3) Meeting any other requirements set forth by the board.

History. Acts 1999, No. 851, § 5.

17-105-106. Exemption from licensure.

Nothing in this chapter shall be construed to require licensure of:

- (1) A physician assistant student enrolled in a physician assistant or surgeon assistant educational program accredited by the Committee on Allied Health Education and Accreditation or by its successor agency;
- (2) A physician assistant employed in the service of the federal government while performing duties incident to that employment;
- (3) Technicians, other assistants, or employees of physicians who perform delegated tasks in the office of a physician but who are not rendering services as a physician assistant or identifying themselves as a physician assistant;
- (4) A physician assistant in the service of the State Military Department or the Arkansas National Guard or both. These physician assistants shall be allowed to perform their physician assistant practice duties, including prescribing, in the same manner as they would if federalized by the United States Government; or
- (5) A physician assistant who is temporarily transiting through the State of Arkansas while caring for a patient, provided that he or she remains under the supervision of his or her supervising physician.

History. Acts 1999, No. 851, § 6.

17-105-107. Scope of authority — Delegatory authority — Agent of supervising physician.

- (a) Physician assistants provide health care services with physician supervision. The supervising physician shall be identified on all prescriptions and orders. Physician assistants may perform those duties and responsibilities, including the prescribing, ordering, and administering drugs and medical devices, that are delegated by their supervising physicians.
- (b) Physician assistants shall be considered the agents of their supervising physicians in the performance of all practice-related activities, including but not limited to, the ordering of diagnostic, therapeutic, and other medical services.
- (c) Physician assistants may perform health care services in any setting authorized by the supervising physician in accordance with any applicable facility policy.
- (d) Nothing in this chapter shall be construed to authorize a physician assistant to:
 - (1) Examine the human eye or visual system for the purpose of prescribing glasses or contact lenses or the determination of the refractive power for surgical procedures;
 - (2) Adapt, fill, duplicate, modify, supply, or sell contact lenses or prescription eye glasses; or

- (3) Prescribe, direct the use of, or use any optical device in connection with ocular exercises, vision training, or orthoptics.

History. Acts 1999, No. 851, § 7.

17-105-108. Prescriptive authority.

- (a) Physicians supervising physician assistants may delegate prescriptive authority to physician assistants to include prescribing, ordering, and administering Schedule III through V controlled substances as described in the Uniform Controlled Substances Act, § § 5-64-101— 5-64-608, and 21 C.F.R. Part 1300, all legend drugs, and all nonschedule prescription medications and medical devices. All prescriptions and orders issued by a physician assistant shall also identify his or her supervising physician.
- (b) At no time shall a physician assistant's level of prescriptive authority exceed that of the supervising physician.
- (c) Physician assistants who prescribe controlled substances must register with the Drug Enforcement Administration as part of the Drug Enforcement Administration's Mid-Level Practitioner registry, 21 C.F.R. Part 1300, 58 FR 31171-31175, and the Federal Controlled Substances Act.

History. Acts 1999, No. 851, § 8.

17-105-109. Supervision.

- (a) Supervision of physician assistants shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place that the services are rendered.
- (b) It is the obligation of each team of physicians and physician assistants to ensure that:
 - (1) The physician assistant's scope of practice is identified;
 - (2) The delegation of medical task is appropriate to the physician assistant's level of competence;
 - (3) The relationship and access to the supervising physician is defined; and
 - (4) A process of evaluation of the physician assistant's performance is established.
- (c) The physician assistant and supervising physician may designate back-up physicians who are agreeable to supervise the physician assistant during the absence of the supervising physician.

History. Acts 1999, No. 851, § 9.

17-105-110. Supervising physician.

A physician desiring to supervise a physician assistant must:

- (1) Be licensed in this state;
- (2) Notify the Arkansas State Medical Board of his intent to supervise a physician assistant; and
- (3) Submit a statement to the board that he will exercise supervision over the physician assistant in accordance with any rules adopted by the board.

History. Acts 1999, No. 851, § 10.

17-105-111. Notification of intent to practice.

- (a) Prior to initiating practice, a physician assistant licensed in this state must submit on forms approved by the Arkansas State Medical Board notification of such intent. The notification shall include:
 - (1) The name, business address, e-mail address, and telephone number of the supervising physician; and
 - (2) The name, business address, and telephone number of the physician assistant.

- (b) A physician assistant shall notify the board of any changes or additions in supervising physicians within ten (10) calendar days.

History. Acts 1999, No. 851, § 11.

17-105-112. Exclusions of limitations of employment.

Nothing in this chapter shall be construed to limit the employment arrangement of a physician assistant licensed under this chapter.

History. Acts 1999, No. 851, § 12.

17-105-113. Violation.

Following the exercise of due process, the Arkansas State Medical Board may discipline any physician assistant who:

- (1) Fraudulently or deceptively obtains or attempts to obtain a license;
- (2) Fraudulently or deceptively uses a license;
- (3) Violates any provision of this chapter or any regulations adopted by the board pertaining to this chapter;
- (4) Is convicted of a felony;
- (5) Is a habitual user of intoxicants or drugs to such an extent that he or she is unable to safely perform as a physician assistant;
- (6) Has been adjudicated as mentally incompetent or has a mental condition that renders him or her unable to safely perform as a physician assistant;
- (7) Has committed an act of moral turpitude; or
- (8) Represents himself or herself as a physician.

History. Acts 1999, No. 851, § 13.

17-105-114. Disciplinary authority.

Upon finding that a physician assistant has committed any offense described in § 17-105-113, the Arkansas State Medical Board may:

- (1) Refuse to grant a license;
- (2) Administer a public or private reprimand;
- (3) Revoke, suspend, limit, or otherwise restrict a license;
- (4) Require a physician assistant to submit to the care, counseling, or treatment of a physician or physicians designated by the board;
- (5) Suspend enforcement of its finding thereof and place the physician assistant on probation with the right to vacate the probationary order for noncompliance; or
- (6) Restore or reissue, at its discretion, a license and impose any disciplinary or corrective measure which it may have imposed.

History. Acts 1999, No. 851, § 14.

17-105-115. Title and practice protection.

- (a) Any person not licensed under this chapter is guilty of a Class A misdemeanor and is subject to penalties applicable to the unlicensed practice of medicine if he or she:
 - (1) Holds himself or herself out as a physician assistant;
 - (2) Uses any combination or abbreviation of the term “physician assistant” to indicate or imply that he or she is a physician assistant; or
 - (3) Acts as a physician assistant.
- (b) An unlicensed physician shall not be permitted to use the title of physician assistant or to practice as a physician assistant unless he or she fulfills the requirements of this chapter.

History. Acts 1999, No. 851, § 15.

17-105-116. Identification requirements.

Physician assistants licensed under this chapter shall keep their license available for inspection at their primary place of business and when engaged in their professional activities shall wear a name tag identifying themselves as a physician assistant.

History. Acts 1999, No. 851, § 16.

17-105-117. Rule-making authority.

- (a) The Arkansas State Medical Board shall promulgate regulations in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., that are reasonable and necessary for the performance of the various duties imposed upon the board by this chapter, including but not limited to:
 - (1) Establishing license renewal dates; and
 - (2) Setting the level of liability coverage.
- (b) The board may levy the following fees:
 - (1) Physician assistant application for licensure fee, eighty dollars (\$80.00);
 - (2) Initial application fee for the physician employer, fifty dollars (\$50.00);
 - (3) Physician assistant annual relicensure fee, fifty dollars (\$50.00);
 - (4) Physician assistant delinquent licensure fee, twenty-five dollars (\$25.00) for each delinquent year or part thereof;
 - (5) Physician assistant application for graduate or temporary licensure fee, ten dollars (\$10.00); and
 - (6) Physician assistant one-time extension graduate licensure fee, forty dollars (\$40.00).
- (c) The board may appoint a physician assistant advisory committee to assist in the administration of this chapter.

History. Acts 1999, No. 851, § 17.

17-105-118. Regulation by the Arkansas State Medical Board.

The Arkansas State Medical Board shall administer the provisions of this chapter under such procedures as it considers advisable and may adopt rules that are reasonable and necessary to implement the provisions of this chapter. Further, it is the intent of the General Assembly that the board on behalf of the General Assembly shall make rules clarifying any ambiguities or related matters concerning this chapter, which may not have been specifically addressed.

History. Acts 1999, No. 851, § 18.

17-105-119. Good Samaritan provision.

Physician assistants shall be subject to the Good Samaritan provisions embodied in § 17-95-101.

History. Acts 1999, No. 851, § 19.

17-105-120. Medical services provided by retired physician assistants to less fortunate patient populations.

- (a) Retired physician assistants may practice their medical services under the supervision of a licensed physician and shall be subject to the same provisions as a retired physician or surgeon would be pursuant to § 17-95-106.
- (b) Retired physician assistants practicing under this provision must continue to be licensed by the Arkansas State Medical Board and must practice their medical skills only under the supervision of a licensed physician.

History. Acts 1999, No. 851, § 20.

17-105-121. Physician assistant employment — Uniform Classification Plan.

- (a) The Office of Personnel Management of the Division of Management Services of the Department of Finance and Administration shall establish and maintain a position

classification of physician assistant. The initial position classification shall mirror the Veterans Health Administration Directive 10-95-020 of March 3, 1995, and the United States Department of Veterans Affairs regulation as embodied in:

- (1) MP-5, Part II, Chapter 2, Change 2, Appendix H; and
- (2) MP-5, Part II, Chapter 5, Change 5.

- (b) Modifications or changes in the future to the state position classification of physician assistant shall only be made based upon the concurrence of the Physician Assistant Advisory Committee.

History. Acts 1999, No. 851, § 21

17-105-122. Physician assistant patient care orders.

- (a) Patient care orders generated by a physician assistant shall be construed as having the same medical, health, and legal force and effect as if the orders were generated by their supervising physician, provided that the supervising physician's name is identified in the patient care order.
- (b) The orders shall be complied with and carried out as if the orders had been issued by the physician assistant's supervising physician.

History. Acts 1999, No. 851, § 22.

17-105-123. Medical malpractice — Professional and legal liability for actions.

Physician assistants shall be covered under the provisions regarding medical malpractice and legal liability as such applies to their supervising physician as embodied in § 16-114-201 — 16-114-203 and 16-114-205 — 16-114-209.

History. Acts 1999, No. 851, § 23.

REGULATION NO. 24 RULES GOVERNING PHYSICIAN ASSISTANTS

1. A physician assistant must possess a license issued by the Arkansas State Medical Board prior to engaging in such occupation.
2. To obtain a license from the Arkansas State Medical Board the physician assistant must do the following:
 - a. Answer all questions to include the providing of all documentation requested on an application form as provided by the Arkansas State Medical Board;
 - b. Pay the required fee for licensure as delineated elsewhere in this regulation;
 - c. Provide proof of successful completion of Physician Assistant National Certifying Examination, as administered by the National Commission on Certification of Physician Assistants;
 - d. Certify and provide such documentation, as the Arkansas State Medical Board should require that the applicant is mentally and physically able to engage safely in the role as a physician assistant;
 - e. Certify that the applicant is not under any current discipline, revocation, suspension or probation or investigation from any other licensing board;
 - f. Provide letters of recommendation as to good moral character and quality of practice history;
 - g. The applicant should be at least 21 years of age;

- h. Show proof of graduation with a Bachelor's Degree from an accredited college or university or prior service as a military corpsman;
 - i. Provide proof of graduation of a physician assistant education program recognized by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs.
 - j. Show successful completion of the Jurisprudence examination as administered by the Arkansas State Medical Board covering the statutes and Rules and Regulations of the Medical Board, the Arkansas Medical Practices Act, the Physician Assistant Act, and the laws and rules governing the writing of prescriptions for legend drugs and scheduled medication;
 - k. The submission and approval by the Board of a protocol delineating the scope of practice that the physician assistant will engage in, the program of evaluation and supervision by the supervising physician;
 - l. The receipt and approval by the Arkansas State Medical Board of the supervising physician for the physician assistant on such forms as issued by the Arkansas State Medical Board;
3. If an applicant for a license submits all of the required information, complies with all the requirements in paragraph 2, except paragraph 2 (k) and the same is reviewed and approved by the Board, then the applicant may request a Letter of Intent from the Board and the Board may issue the same. Said Letter of Intent from the Board will state that the applicant has complied with all licensure requirements of the Board except the submission of a protocol and supervising physician and that upon those being submitted and approved by the Board, it is the intent of the board to license the applicant as a physician assistant.
 4. The Protocol.
 - a. This protocol is to be completed and signed by the physician assistant and his designated supervising physician. Said protocol will be written in the form issued by the Arkansas State Medical Board. Said protocol must be accepted and approved by the Arkansas State Medical Board prior to licensure of the physician assistant.
 - b. Any change in protocol will be submitted to the Board and approved by the Board prior to any change in the protocol being enacted by the physician assistant.
 - c. The protocol form provided by the Board and as completed by the physician assistant and the supervising physician will include the following:
 - (1) area or type of practice;
 - (2) location of practice;
 - (3) geographic range of supervising physician;
 - (4) the type and frequency of supervision by the supervising physician;
 - (5) the process of evaluation by the supervising physician;
 - (6) the name of the supervising physician;
 - (7) the qualifications of the supervising physician in the area or type of practice that the physician assistant will be functioning in;
 - (8) the type of drug prescribing authorization delegated to the physician assistant by the supervising physician;
 - (9) the name of the back-up supervising physicians and a description of when the back-up supervising physician will be utilized.
 5. A. A physician assistant must be authorized by his supervising physician to prescribe legend drugs and scheduled

medicine for patients. Said authorization must be stated in the protocol submitted by the physician assistant to the Board and approved by the Board. A supervising physician may only authorize a physician assistant to prescribe schedule medication that the physician is authorized to prescribe. A physician assistant may only be authorized to prescribe schedule III through V medications. Prescriptions written by a physician assistant must contain the name of the supervising physician on the prescription.

- B. The physician assistant will make an entry in the patient chart noting the name of the medication, the strength, the dosage, the quantity prescribed, the directions, the number of refills, together with the signature of the physician assistant and the printed name of the supervising physician for every prescription written for a patient by the physician assistant.
 - C. The supervising physician shall be identified on all prescriptions and orders of the patient in the patient chart if issued by a physician assistant.
6. A supervising physician should be available for immediate telephone contact with the physician assistant any time the physician assistant is rendering services to the public. A supervising physician must be able to reach the location of where the physician assistant is rendering services to the patients within one hour.
7. A. The supervising physician for a physician assistant must fill out a form provided by the Board prior to him becoming a supervising physician. Said supervising physician must provide to the Board his name, business address, licensure, his qualifications in the field of practice in which the physician assistant will be practicing and the name(s) of the physician assistant(s) he intends to supervise.
- B. The supervising physician must submit to the Board a notarized letter stating that they have read the regulations governing physician assistant and will abide by them and that they understand that they take full responsibility for the actions of the physician assistant while that physician assistant is under their supervision.
- C. Back-up or alternating supervising physicians must adhere to the same statutory and regulatory rules as the primary supervising physician.
8. A. Physician assistants provide medical services to patients in a pre-approved area of medicine. Physician assistants will have to provide medical services to the patients consistent with the standards that a licensed physician would provide to a patient. As such, the physician assistant must comply with the standards of medical care of a licensed physician as stated in the Medical Practices Act, the Rules and Regulations of the Board and the Orders of the Arkansas State Medical Board. A violation of said standards can result in the revocation or suspension of the license when ordered by the Board after disciplinary charges are brought.
- B. A physician assistant must clearly identify himself or herself to the patient by displaying an appropriate designation, that is a badge, name plate with the words "physician assistant" appearing thereon.
- C. A physician assistant will not receive directly from a patient or an insurance provider of a patient any monies for the services he or she renders the patient. Payment of any bills or fees for labor performed by the physician

assistant will be paid to the employer of the physician assistant and not directly to the physician assistant.

9. The supervising physician is liable for the acts of a physician assistant whom her or she is supervising if said acts of the physician assistant arise out of the powers granted the physician assistant by the supervising physician. The supervising physician may have charges brought against him by the Arkansas State Medical Board and receive sanctions if the physician assistant should violate the standards of medical practice as set forth in the Medical Practices Act., the Rules and regulations of the Board and the standards of the medical community.
10. Continuing Medical Education:
- a. A physician assistant who holds an active license to practice in the State of Arkansas shall complete 20 credit hours per year continuing medical education.
 - b. If a person holding an active license as a physician assistant in this State fails to meet the foregoing requirement because of illness, military service, medical or religious missionary activity, residence in a foreign country, or other extenuating circumstances, the Board upon appropriate written application may grant an extension of time to complete the same on an individual basis.
 - c. Each year, with the application for renewal of an active license as a physician assistant in this state, the Board will include a form which requires the person holding the license to certify by signature, under penalty of perjury, and disciplined by the Board, that he or she has met the stipulating continuing medical education requirements. In addition, the Board may randomly require physician assistants submitting such a certification to demonstrate, prior to renewal of license, satisfaction of continuing medical education requirements stated in his or her certification.
 - d. Continuing medical education records must be kept by the licensee in an orderly manner. All records relative to continuing medical education must be maintained by the licensee for at least three years from the end of the reporting period. The records or copies of the forms must be provided or made available to the Arkansas State Medical Board.
 - e. Failure to complete continuing education hours as required or failure to be able to produce records reflecting that one has completed the required minimum medical education hours shall be a violation and may result in the licensee having his license suspended and/or revoked.

History: Adopted December 7, 1977; Amended October 9, 1999; Amended December 10, 1999; Amended February 4, 2000; Amended April 8, 2005; Amended June 5, 2008

Replaced Regulation 4