

**\*\*\*\*\*NOTICE\*\*\*\*\***

**This Is A Requirement For Licensure**

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

**The Medical Practices Act can be viewed at [www.armedicalboard.org](http://www.armedicalboard.org). Go to the Help Desk and then Downloads.**

# **Attention Prospective Applicants and Current Licensees**

**Effective July 1, 2005**

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

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

**Arkansas code 17-95-306 states:**

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

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

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



# ARKANSAS STATE MEDICAL BOARD

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

[www.armedicalboard.org](http://www.armedicalboard.org)

## IMPORTANT INFORMATION – PLEASE READ CAREULLY

Dear Physician Assistant:

Enclosed is an application for Physician Assistant Licensure in the State of Arkansas. We welcome you and are glad you have chosen to work in our state.

It is important for you to understand the licensure process may take several weeks to complete. This depends totally on your work history and the timeliness of the responses we receive from your verification requests. If you have a history of malpractice, disciplinary action, impairment history, etc., additional time will be required for our investigation. Applications are processed in the order in which they are received in our office. **THE BOARD DOES NOT ACCELERATE ONE APPLICANT OVER ANOTHER.**

To insure efficiency, please type or print legibly on your application and read the instructions for each question carefully before answering. Make sure all required seals are affixed on the application, all questions have a response and all documentation has been certified. **ANSWER ALL QUESTIONS.** If the question does not pertain to you, write “Not Applicable” or “N/A”. Your application or verifications will be returned to you if not complete or if photos are not attached where required. The process will cease until the application has been completed correctly and returned to this office. This will only lengthen your waiting time. Faxed copies and stamped signatures **ARE NOT** accepted for documentation or verification purposes. Answering the question by “see attached list” is not acceptable.

Act 1249 of 2005 has authorized the Arkansas State Medical Board to conduct criminal background checks (both state and federal) on applicants for licensure. Upon receipt in this office of your completed application and fee, instructions will be forwarded to you on the process for obtaining the background check.

Upon receipt of your completed application, it will be reviewed to determine the status. You will receive a letter of acknowledgement from this office advising you of anything needed to complete your file.

### INSTRUCTIONS FOR COMPLETING APPLICATION

*Question 1:* Enter your legal name. If your name has changed due to marriage, divorce, adoption or naturalization, submit a notarized copy of pertinent document. Enter your Social Security Number for identification purposes.

*Question 2:* Enter your name as listed on your Driver’s License, your Driver’s License number and the state in which it is registered. Include a copy of this with your application.

*Question 3 & 4:* Enter your current mailing address and the mailing address where you wish your Arkansas license to be mailed.

*Question 5:* Enter your Residence and Work telephone numbers, your fax number and email address.

*Question 6:* Check whether male or female and indicate your Birth Date, Birthplace and Race. If born outside the U.S., enter the length of time you have lived in the U.S. and whether you are a citizen of the U.S. If you answered, “Yes”, and you are Foreign born, attach proof of citizenship. If you answered, “No”, indicate your status with U.S. Immigration and attach a copy of your current Visa or Work Permit.

*Question 7:* Enter the address of your intended work location and the name and address of the office, clinic, hospital, etc. Enter the name and specialty of your Supervising Physician and Backup Supervising Physician. Please note that 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.*

*Question 8:* Enter the dates you graduated from Undergraduate and Physician Assistant School. Complete the top portions of the Undergraduate Education and Physician Assistant Education Forms provided in your application packet, attach recent photos in the spaces provided on the forms, and mail the forms to your Undergraduate and Physician Assistant Schools. The schools will complete the bottom portions, and return the forms with Official Transcripts direct to this office. The completed forms will not be accepted by the Board without the required photos attached.

*Question 9:* Complete the NCCPA Request and Authorization for Release of Information form and send to the NCCPA. If you have not yet taken your exam, request the Eligibility Letter be sent, if you have taken and passed request the Exam Results be sent. This can be obtained by going to the following web address: <http://www.nccpa.net/pdfs/information%20release%20form.pdf>

*Question 10:* Complete this portion if you currently hold, or have ever had, any other state licenses (included any temporary or training permits). Complete the top portion of the License Verification form provided in your application packet (you may copy the form, if necessary). Mail the form to each of the State Licensing Boards where you have been licensed. The completed form will be returned direct to this office.

**Question 11:** Enter your complete work history since graduation from Physician Assistant School to the present. If additional space is needed, indicate on the application that a separate sheet is attached. Do not enter, "See attached resume or CV"; however, you should include a copy of your current CV with your application.

**Question 12:** List the names, addresses and association of three (3) professional references. Request they mail recommendation letters direct to the Board. One of these recommendations should be from your most recent supervisor. To assure timely processing of your application, please communicate the following guidelines for submitting recommendation letters to the Board:

- Letters must be written/typed on standard size paper or letterhead and must include the date, address and phone number of the sender. The name of the sender must be legible.
- Recommendation letters must be addressed to the Arkansas State Medical Board and state they are recommending you for licensure in Arkansas.
- Letters must include your full, legal name. If an alternate name is used, your full, legal name must be included in the letter (Example, RE: John Paul Smith).
- Letters from the same organization must not be identical "form" letters and must be mailed separately.

**Question 13:** List the names, addresses and association of two (2) physicians with whom you have worked and have them submit letters of recommendation. Both professional references and physician recommendation letters must:

- Have personal comments about the applicant
- Indicate whether or not they have worked with the applicant and state the work experience with the PA regarding their knowledge base
- Indicate their observation of the PA's integrity or character
- Can not be from someone who will be your Arkansas Supervising Physicians

**Questions 14 to 25:** Include on a separate sheet, an explanation to any "Yes" response to any of these questions.

**Question 14 - Misdemeanor or Felony conviction** – attach explanation and copy of original indictment, judgment or conviction, indicate whether paroled or placed on probation and how probation was completed. Please note that if you have or had a record which is sealed, expunged or pardoned, you are still required to answer "yes" to this question.

**Question 26:** Provide a copy of your DEA Registration Card. If DEA registration is pending you will need to provide a copy upon receipt.

**Question 27:** As part of the application process, the Arkansas State Medical Board requires verification if you hold Professional Liability Insurance. If this is pending, you will need to provide a copy upon receipt.

**Question 28:** Indicate if you have ever been in the military (whether foreign or in the United States) and if so, which branch and the dates of service. Attach a copy of your separation papers (DD-214) and contact the military personnel records center for verification of dates of service, verification of military hospitals, disciplinary problems, drug or substance abuse or mental or emotional impairments. Send the enclosed military verification form to the agency and address listed on the form or the applicable service branch records office, for verification.

**Affidavit of Applicant:** The applicant must attach a recent photograph in the space provided and sign the photograph before 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.*

**Authorization and Release:** Read and sign the Authorization and Release included in your application packet and return to this office with your application so the Board may obtain further information or verification if necessary.

**Supervising Physician Application:** Have your supervising physician complete the Supervising Physician Application provided in your application packet, include the required \$50 Physician's fee, notarize as indicated, a copy of their DEA, a copy of their current liability insurance, signed protocol and signed Rules and Regulation Affidavit and return to this office. These items must be mailed together.

**Backup Supervising Physician Application:** Have your backup supervising physician complete the Backup Supervising Physician Application provided in your application packet, include the signed Rules and Regulation Affidavit, the signed Scope of Practice statement and signed protocol and return to this office.

**License Application Fees:** \$90 Full License (\$80 for Application Fee and \$10 for Temporary License); \$90 for a Graduate License (only issued in extreme situations) (\$80 for application fee and \$10 for Graduate License). A Graduate License may be issued only in extreme situations. Include the appropriate fees with your application. Personal or business checks and money orders are accepted.

*Temporary Licenses:* **The Physician Assistant must take and successfully pass the NCCPA exam before receiving a temporary permit. The NCCPA exam can be taken 7 days after program graduation and once in any 90 day period or three 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 Advisory Committee. No more than two (2) temporary permits will be issued and they must appear with their Supervising Physician for approval of protocol within the 4-month timeframe.**

*Jurisprudence Exam:* **Applicants are required to successfully complete the jurisprudence exam prior to licensure. Complete the exam included in your application packet and return when submitting your application. This is a requirement for licensure.**

*Committee Appearance:* **All applicants and supervising physicians will be required to appear before the Physician Assistant Advisory Committee prior to licensure and also when changing supervising physicians.**



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX (501) 296-1805  
[www.armedicalboard.org](http://www.armedicalboard.org)

## APPLICATION FOR PHYSICIAN ASSISTANT LICENSURE IN ARKANSAS

Full License     Temporary License     Graduate License

1. Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
(Legal Name. If name on documentation is not the same as above, submit a copy of legal name change.)

2. Name as listed on your Driver's License \_\_\_\_\_

3. Address \_\_\_\_\_

4. Address you wish license to be mailed \_\_\_\_\_

5. Phone (Res.) \_\_\_\_\_ (Work) \_\_\_\_\_ (Fax) \_\_\_\_\_ (Email) \_\_\_\_\_

6. Male  Female  Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Place \_\_\_\_\_ Race \_\_\_\_\_  
If born outside of U.S., how long have you lived in U.S. \_\_\_\_Years \_\_\_\_ Months. Are you a citizen of U.S.? \_\_\_\_ Yes \_\_\_\_ No

**If yes, and foreign born, attach proof of citizenship. If no, indicate your status with U.S. Immigration** \_\_\_\_\_  
(Attach copy of your Visa/Work Permit)

7. Intended location in Arkansas \_\_\_\_\_

Name of Supervising Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Name of Backup Supervising Physician \_\_\_\_\_ Specialty \_\_\_\_\_

8. Education: Undergraduate Date Graduated: mo \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ Degree \_\_\_\_\_

Physician Assistant Program Date Graduated: mo \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ Degree \_\_\_\_\_

**List in chronological order the name and location of each college, university, or technical school attended.**

Complete Name of Institution	Complete Address	Date From	Date To

**Have Verification of Undergraduate and Physician Assistant Education Forms and Official Transcripts mailed directly to this office.**

9. Have you passed the NCCPA Examination? \_\_\_\_\_ Yes \_\_\_\_\_ No

**If yes, have certification from NCCPA mailed directly to this office.**

**If no, send a notarized copy of your verification to sit for the next exam.**

10. List all states in which you have or have had a Physician Assistant license. **Have verification of each state license mailed directly to this office. Send enclosed Verification of Licensure form. (Form may be copied)**

State	License #	Date Issued	Active Y/N

State	License #	Date Issued	Active Y/N

11. Professional Activities

List in chronological order all your professional activities, institutional affiliations or places of employment since graduation from Physician Assistant School.

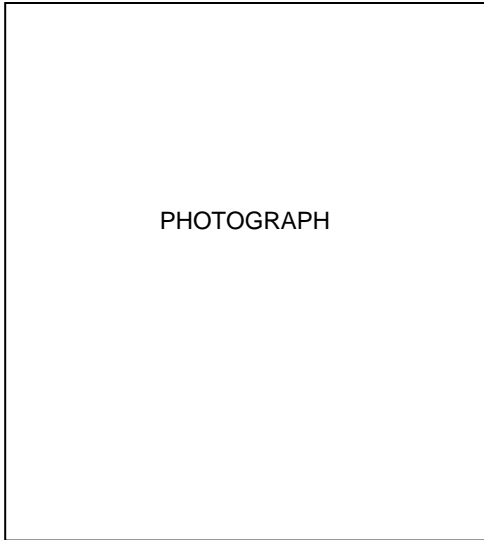
From	To	Status	Location & Complete Address	Position

- **Please review this list carefully. If there are gaps in your chronological history you are required to provide a brief explanation.** Send enclosed Verification Hospital/Clinic forms to each facility. (See Instruction Sheet)

12. Professional Recommendations: **Have three (3) recommendation letters mailed directly to this office.** These recommendations may not be related to you. They must have worked with you and directly observed your work performance in the recent past. At least one of these recommendations must have had organizational responsibility for supervising your performance (i.e., department chief, or training program director).

NAME	ADDRESS	ASSOCIATION





**NOTARY SEAL MUST  
BE AFFIXED  
PARTIALLY ON  
PHOTOGRAPH**

**AFFIDAVIT OF APPLICANT**

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

Date \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

County of \_\_\_\_\_

State of \_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

-----  
DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Application received: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Fee Received: \$\_\_\_\_\_.00 Date: \_\_\_\_\_

Temporary License Number \_\_\_\_\_

Temporary License Issued: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Expiration Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Full License Issued: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Arkansas Physician Assistant License Number: \_\_\_\_\_

Approval Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_



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[www.armedicalboard.org](http://www.armedicalboard.org)

## VERIFICATION OF UNDERGRADUATE EDUCATION

\_\_\_\_\_  
Name of Institution

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip

I, \_\_\_\_\_, Physician Assistant, have applied for a license to work in the state of  
*(Print full name)*

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

I hereby authorize \_\_\_\_\_, its staff, or representative to provide the Arkansas State Medical  
*(Name of school or college)*

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

Sincerely, \_\_\_\_\_  
*(Signature of Applicant)*

Date or Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MO DAY YR

Social Security Number \_\_\_\_\_

Date of Graduation \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MO DAY YR

**For verification of UNDERGRADUATE EDUCATION ONLY. Please provide exact dates.**

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

This certifies that \_\_\_\_\_  
*(Full name of applicant)*

Enrolled in \_\_\_\_\_  
*(Name of College or University)*

on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ graduated \_\_\_\_ / \_\_\_\_ / \_\_\_\_ with a degree in \_\_\_\_\_  
MO DAY YR MO DAY YR

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

**AN OFFICIAL SCHOOL TRANSCRIPT MUST BE RETURNED WITH THIS FORM**

By \_\_\_\_\_  
Signature of the dean or registrar **(No Stamped Signatures)**

**SEAL**

*Attach  
Passport size  
Photograph  
here*

Signed and the college Seal affixed on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MO DAY YR

Phone \_(\_\_\_\_) \_\_\_\_\_ Fax \_(\_\_\_\_) \_\_\_\_\_

**School seal MUST be imprinted partially on photograph.**



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## VERIFICATION OF PHYSICIAN ASSISTANT EDUCATION

\_\_\_\_\_  
Name of Institution

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip

I, \_\_\_\_\_, Physician Assistant, have applied for a license to work in the state of  
*(Print full name)*  
Arkansas. As part of the application process, the Arkansas State Medical Board requires verification of my **Physician Assistant Education**.

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

Sincerely, \_\_\_\_\_  
*(Signature of Applicant)*

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MO DAY YR

Social Security Number \_\_\_\_\_

Date of Graduation \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MO DAY YR

**For verification of PHYSICIAN ASSISTANT EDUCATION ONLY. Please provide exact dates.**

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

This certifies that \_\_\_\_\_  
*(Full name of applicant)*

Enrolled in \_\_\_\_\_  
*(Name of Physician Assistant School, College or University)*

on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ graduated \_\_\_\_ / \_\_\_\_ / \_\_\_\_ with a degree in \_\_\_\_\_  
MO DAY YR MO DAY YR

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

**AN OFFICIAL SCHOOL TRANSCRIPT MUST BE RETURNED WITH THIS FORM**

By \_\_\_\_\_  
Signature of the dean or registrar **(No Stamped Signatures)**

**SEAL**

*Attach  
Passport size  
Photograph  
here*

Signed and the college Seal affixed on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MO DAY YR

**Physician Assistant school seal MUST be imprinted partially on photograph.**



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2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX: (501) 296-1805

[www.armedicalboard.org](http://www.armedicalboard.org)

## PROFESSIONAL LIABILITY VERIFICATION

Name of Institution \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I, \_\_\_\_\_, Physician Assistant have applied for a license to practice medicine in the state of Arkansas. As part of the application process, the Arkansas State Medical Board requires verification of my **Liability Insurance**.

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

Sincerely, \_\_\_\_\_ Social Security Number \_\_\_\_\_  
(Signature)

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO DAY YR

### For verification of PROFESSIONAL LIABILITY

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

This certifies that \_\_\_\_\_  
( Full name of applicant)

\_\_\_\_\_  
(Carrier) (Policy Number) (Policy Amount)

Dates of Coverage (beginning) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to (expires) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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

Yes No

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

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

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

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

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_



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2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX: (501) 296-1805

[www.amedicalboard.org](http://www.amedicalboard.org)

## VERIFICATION OF LICENSURE

I, \_\_\_\_\_, Physician Assistant, hereby authorize and request the state board of \_\_\_\_\_, having control of any documents, records, and other information pertaining to me, to furnish to the Arkansas State Medical Board all information requested on this form and any pertinent information regarding final actions taken against my license to work as a Physician Assistant.

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

**For verification of LICENSURE**  
Please provide exact dates.

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

State of	Full name of licensee
----------	-----------------------

Graduate Of	License Number	Issue Date ____/____/____ MO DAY YR
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Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Active  Inactive  Lapsed  Other (Explain on back)

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

Comments, if any

Board Seal must be affixed	Signature and Title	Date ____/____/____ MO DAY YR
	State Board	Phone: (    ) _____ Fax: (    ) _____



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## VERIFICATION OF HOSPITAL/CLINIC PHYSICIAN ASSISTANT AFFILIATION

Name of Office or Facility \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I, \_\_\_\_\_, PA, have applied for a license to practice medicine in the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each facility in which I have or have had Privileges or Employment.

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

Sincerely, \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number \_\_\_\_\_  
MO DAY YR

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

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

I, \_\_\_\_\_ state that the above named Physician Assistant was employed at our hospital/clinic office from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_.  
(Print Full Name) MO DAY YR MO DAY YR

Indicate the scope of employment: \_\_\_\_\_.

During the stated period of time, the privileges of this individual (check one)  Were  Were not Denied, Revoked, Suspended, Limited, Reduced, Not Renewed or Relinquished (whether by resignation or expiration, voluntarily or involuntarily).

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

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

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

Enter Date Signed MO / DAY / YR

( ) ( )  
Telephone Number Fax Number



# **ARKANSAS STATE MEDICAL BOARD**

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

## **VERIFICATION OF MILITARY SERVICE**

Mail to:

**National Archives and Records Center** (or specific military branch office or commanding officer)

**Military Personnel Records**

**9700 Page Ave.**

**St. Louis, MO 63132**

I \_\_\_\_\_, authorize the

Print or type full name

**National Personnel Records Center, or the custodian of my military service record to release to the Arkansas State Medical Board the following information and/or copies of documents from my military service record.**

**Copy of separation papers (DD-214)**

**Records of military hospital privileges.**

**Records of Internship, Residencies or Fellowships completed in the military.**

**Any disciplinary problems, drug or substance abuse or mental or emotional impairments.**

**Dates of Service:** \_\_\_\_\_

**Current Status:** \_\_\_\_\_  
(\*Active, Inactive, Retired, Reserves, etc.)

**Branch:** \_\_\_\_\_

**SS#:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Signed:** \_\_\_\_\_

**Date Signed** \_\_\_\_\_

**NOTE: Attach a copy of your signed Authorization & Release to this request prior to mailing.**

\*Circle One

Active duty military should mail verifications to current station, commanding officer.

Rev 1/01 ann



Arkansas State Medical Board  
2100 Riverfront Drive  
Little Rock, AR 72202  
Phone: (501) 296-1802  
Fax: (501) 296-1805  
[www.armedicalboard.org](http://www.armedicalboard.org)

## Authorization to Release Pending Licensure Application File Information

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

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

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

---

*(Print full name of Representative)*

---

*(Email address of Representative)*

---

*(Phone number of Representative)*

---

*(Print full name of Applicant)*

---

*(Signature of Applicant)*

---

*(Date Signed)*

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

**PHYSICIAN ASSISTANT  
AUTHORIZATION AND RELEASE**

**To Whom It May Concern:**

**This document will authorize and direct any physicians with whom I have been associated, employees and medical staff members of any medical facility or hospital where I have been employed or on staff or associated, or any employees of any malpractice insurance carriers, or any state medical licensing boards where I have been licensed or have applied for a license, or any medical clinics where I have been employed or associated, or any physician assistant schools where I have attended, or other individuals with whom I have been associated 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, professional performance reviews, medical charts that I have made and evaluations of my performance.**

**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 shall remain in effect until specifically revoked by me in writing.**

**Typed or Printed Name of Physician Assistant: \_\_\_\_\_**

**Signature of Physician Assistant: \_\_\_\_\_ Date: \_\_\_\_\_**



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX: (501) 296-1805

[www.armedicalboard.org](http://www.armedicalboard.org)

## ARKANSAS RULES AND REGULATIONS AFFIDAVIT

I, \_\_\_\_\_ on this date, \_\_\_\_\_  
(Type or Print Name of Physician Assistant)

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

Signed: \_\_\_\_\_  
(Physician Assistant Signature)

Date: \_\_\_\_\_

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



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX: (501) 296-1805

[www.armedicalboard.org](http://www.armedicalboard.org)

## PHYSICIAN ASSISTANT SUPERVISING PHYSICIAN APPLICATION

1. Physician Assistant's Name: \_\_\_\_\_
  2. Supervising Physician's Name: \_\_\_\_\_ License #: \_\_\_\_\_
  3. Supervising Physician's Address: \_\_\_\_\_
  4. Supervising Physician's Phone Numbers: Office: \_\_\_\_\_ Home: \_\_\_\_\_ Fax: \_\_\_\_\_
  5. Supervising Physician's Medical School, Address and Date of Graduation: \_\_\_\_\_  
\_\_\_\_\_
  6. Supervising Physician's Specialty: \_\_\_\_\_ Board Certified? \_\_\_ Yes \_\_\_ No
  7. Type or Scope of Practice of Supervising Physician: \_\_\_\_\_
    - (a) Services Rendered: \_\_\_\_\_  
\_\_\_\_\_
    - (b) Area or Geographic Range of Supervising Physician: \_\_\_\_\_  
\_\_\_\_\_
    - (c) Type of Facility: Office \_\_\_\_\_ Clinic \_\_\_\_\_ Hospital \_\_\_\_\_ Other \_\_\_\_\_
  8. Attach a legible copy of your Drug Enforcement Administration (DEA) certificate and current liability insurance.
  9. Name, Address and License Number of the back-up Supervising Physician(s) who will supervise Physician's Assistant in your absence, and a description of when the back-up Supervising Physician will be utilized:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Attach additional sheets, as necessary

10. List any Physician Assistants you currently provide supervision to. Include the PA's name and license number with designation of your supervision, i.e., Supervising Physician or Backup Supervising Physician:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Supervising Physician)

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

SUBSCRIBED AND SWORN To before me, a Notary Public, this \_\_\_\_\_ day

of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Commission Expires)

\_\_\_\_\_  
(Signature of Notary Public)

NOTARY  
SEAL

The following must be included when submitting this application:

1. A fee of **\$50.00** to be paid by the supervising physician must accompany this application. Checks should be made payable to the Arkansas State Medical Board.
2. Signed Rules and Regulation Affidavit
3. Copy of the Supervising Physician's DEA certificate
4. Copy of the Supervising Physician's current liability insurance certificate
5. Signed protocol

**Failure to submit the above required items together will result in a delay of the application process**

\_\_\_\_\_ **FOR USE BY OFFICE ONLY** \_\_\_\_\_

Application Received: \_\_\_\_\_

Fee Received: \$ \_\_\_\_\_ .00

Date Approved: \_\_\_\_\_



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX: (501) 296-1805

[www.armedicalboard.org](http://www.armedicalboard.org)

## ARKANSAS RULES AND REGULATIONS AFFIDAVIT

I, \_\_\_\_\_ on this date, \_\_\_\_\_,  
*(Type or Print Name of Supervising Physician)*

do affirm that I have read the Physician Assistant Act, Arkansas Code 17-95-101, *et seq.*, Medical Practices Act 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.

*(Type or Print Name of Physician Assistant)*

Signed: \_\_\_\_\_  
*(Supervising Physician Signature)*

Date: \_\_\_\_\_

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



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX: (501) 296-1805

[www.armedicalboard.org](http://www.armedicalboard.org)

## PHYSICIAN ASSISTANT BACK-UP SUPERVISING PHYSICIAN APPLICATION

1. Physician Assistant's Name: \_\_\_\_\_
  
2. Back-up Physician's Name: \_\_\_\_\_ License #: \_\_\_\_\_
  
3. Back-up Physician's Address: \_\_\_\_\_
  
4. Back-up Physician's Phone Numbers: Office: \_\_\_\_\_ Home: \_\_\_\_\_ Fax: \_\_\_\_\_
  
5. Back-up Physician's Medical School, Address and Date of Graduation: \_\_\_\_\_  
\_\_\_\_\_
  
6. Back-up Physician's Specialty: \_\_\_\_\_ Board Certified? \_\_\_ Yes \_\_\_ No
  
7. Type or Scope of Practice of Back-up Physician: \_\_\_\_\_  
  - (a) Services Rendered: \_\_\_\_\_  
\_\_\_\_\_
  - (b) Area or Geographic Range of Back-up Physician: \_\_\_\_\_  
\_\_\_\_\_
  - (c) Type of Facility: Office \_\_\_\_\_ Clinic \_\_\_\_\_ Hospital \_\_\_\_\_ Other \_\_\_\_\_
  
8. Name, Address and License Number of Primary Supervising Physician:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
9. List any Physician Assistants you currently provide supervision to. Include the PA's name and license number with designation of your supervision, i.e., Supervising Physician or Backup Supervising Physician:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Supervising Physician)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Backup Physician)

STATE OF \_\_\_\_\_  
COUNTY OF \_\_\_\_\_

SUBSCRIBED AND SWORN To before me, a Notary Public, this \_\_\_\_\_ day  
of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Commission Expires)

\_\_\_\_\_  
(Signature of Notary Public)

NOTARY  
SEAL

**The following must be included when submitting this application:**

- 1. Signed Rules and Regulation Affidavit
- 2. Signed Backup Supervising Physician Scope of Practice Statement
- 3. Signed protocol

**Failure to submit the above required items together will result in a delay of the application process**

**FOR USE BY OFFICE ONLY**

Application Received: \_\_\_\_\_

Date Approved: \_\_\_\_\_



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX: (501) 296-1805

[www.armedicalboard.org](http://www.armedicalboard.org)

## ARKANSAS RULES AND REGULATIONS AFFIDAVIT

I, \_\_\_\_\_ on this date, \_\_\_\_\_,  
*(Type or Print Name of Back-up Physician)*

do affirm that I have read the Physician Assistant Act, Arkansas Code 17-95-101, *et seq.*, Medical Practices Act 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.

*(Type or Print Name of Physician Assistant)*

Signed: \_\_\_\_\_  
*(Back-up Physician Signature)*

Date: \_\_\_\_\_

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



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802 FAX: (501) 296-1805

[www.armedicalboard.org](http://www.armedicalboard.org)

## BACKUP 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 PA in the absence of the Supervising Physician.**

Signed: \_\_\_\_\_  
(Backup Physician Signature)

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Physician Assistant: \_\_\_\_\_

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

**Arkansas State Medical Board  
Attn: Physician Assistant Licensing  
2100 Riverfront Drive  
Little Rock, AR 72202**

(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 PA)**

Name of Facility

**List all locations PA will work**

Address of Facility

Phone Number of Facility

Fax Number of Facility

**Supervising Physician:** \_\_\_\_\_ **License #:** \_\_\_\_\_

**\*Backup Supervising Physician:** \_\_\_\_\_ **License #:** \_\_\_\_\_

\*Add additional lines as 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
- other types of services (must be specified)

**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 by classes of drugs and location to be administered)
- 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
- other types of services (must be specified, i.e., joint injections (elbow, knee...))

**Procedures requiring onsite 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 PA’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 onsite 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’s assistant and would always be available via phone.

The physician assistant will not practice if the supervising physician or the back-up supervising physician is physically absent or not physically available within 60 minutes.

**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 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 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 counter signed 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 Supervising Physician:* \_\_\_\_\_ *Date:* \_\_\_\_\_

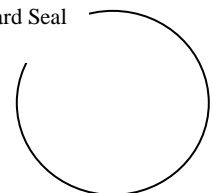
*\*(Please add appropriate signatures lines for additional back up supervising physicians)*

*Signature of Arkansas State Medical Board:*

\_\_\_\_\_  
*PA Chairman*

\_\_\_\_\_  
*Date*

Board Seal



Name: \_\_\_\_\_

Date: \_\_\_\_\_

**PHYSICIAN ASSISTANT  
JURISPRUDENCE EXAM II**

1. \_\_\_\_ If a physician assistant violates the standards of the medical practice as set forth in the Medical Practices Act and the 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 and approved by the Board.
4. \_\_\_\_ A physician assistant is only authorized to prescribe scheduled medications, which 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 the NCCPA exam.
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/her self 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 himself or 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 to include 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 per year continuing medical education.
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.