

**\*\*\*\*\*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 Radiologist Assistant/Radiology Practitioner Assistant license to the Arkansas State Medical Board. You must complete the Rules and Regulations 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, PA, RA and RPA – must complete a criminal background check and/or authorize the Arkansas State Medical Board to conduct such check.

Arkansas Code 17-95-306 states:

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

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

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

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



# 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)

## IMPORTANT INFORMATION – PLEASE READ CAREFULLY

Dear Radiologist Assistant:

Enclosed is an application for Radiologist 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 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.**

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 of your completed application and fee in this office, 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 your driver's license 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 you are 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 of your Supervising Radiation Practitioner and Alternate Supervising Radiologist. Please note that Regulation 29 (V) states:  
*Supervising and alternate supervising radiation practitioners must have the privileges to perform the procedures for which he/she is supervising for the RA and RPA.*

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

*Question 9:* Complete the Request and Authorization for Release of Information form and send to the ARRT. If you have not yet taken your exam, request the Eligibility Letter be sent. If you have taken and passed the exam, request the Exam Results be sent direct to our office. This can be obtained by going to the following web address: [www.rrrt.org](http://www.rrrt.org)

**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 Radiologist 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 two (2) 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 one (1) physician with whom you have worked and have them submit a letter of recommendation. Both professional references and physician recommendation letters must:

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

**Question 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 a record which is sealed, expunged or pardoned, you are still required to answer "yes" to this question.

**Question 26:** 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 Radiation Practitioner Application:** Have your supervising practitioner complete the Supervising Radiation Practitioner Application provided in your application packet; notarize as indicated, include a copy of their current DEA, a copy of their current liability insurance, signed Practice Specific document and signed Rules and Regulation Affidavit and return to this office. These items must be mailed together.

**Alternate Supervising Radiologist Application:** Have your alternate supervising Radiologist complete the Alternate Supervising Radiologist Application provided in your application packet, include the signed Rules and Regulation Affidavit and the signed Practice Specific Document and return to this office.

**License Application Fees:** \$75 for Radiologist Assistant License; Renewal Fee of \$50. Include the appropriate fees with your application. Personal or business checks and money orders are accepted.



11. Previous Radiologist Assistant Employment

List in chronological order all your places of employment since graduation from Radiologist Assistant or Radiology Practitioner Assistant program beginning with your most recent position.

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 of Hospital/Clinic forms to each facility. (See Instruction Sheet)

12. Professional Recommendations: **Have three (3) recommendation letters mailed directly to this office.** These recommenders 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

13. Physician References: **Have two (2) physicians whom you have worked with as a Radiologist Assistant or Radiology Practitioner Assistant submit letters of recommendation directly to this office.**

NAME	ADDRESS

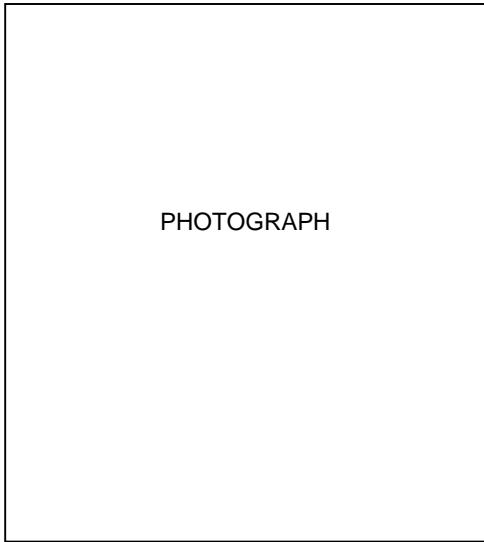
**Attach Explanation of any "Yes" Answer**

**YES**

**NO**

- |   |       |       |
|---|-------|-------|
| 14. Have you ever been charged with or convicted of a misdemeanor or felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.) | _____ | _____ |
| 15. Do you have any physical, mental or emotional impairment? If "Yes", explain.  | _____ | _____ |
| 16. Have you ever been addicted to alcohol or drugs?  | _____ | _____ |
| 17. Have you ever had a DWI or DUI? How many? _____   | _____ | _____ |
| 18. 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.  | _____ | _____ |
| 19. Has any licensing board ever placed your license on probation, suspension, or has it revoked a license or certificate granted you? If yes, list name and address of Board on an attachment.                             | _____ | _____ |
| 20. Have you ever been ordered to appear before a Licensing Board for any reason other than licensure?  | _____ | _____ |
| 21. Have disciplinary procedures ever been initiated toward you by either a Licensing Board or Hospital? If yes, explain in an attachment.  | _____ | _____ |
| 22. Have you ever voluntarily surrendered your license in any other state?  | _____ | _____ |
| 23. Have you ever previously made application to the Arkansas State Medical Board?  | _____ | _____ |
| 24. Have any malpractice claims been filed against you? <b>If yes, provide official documentation from your attorney or insurance company.</b>  | _____ | _____ |
| 25. To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? <b>If yes, explain.</b>   | _____ | _____ |
| 26. Military Service? _____ Yes _____ No If yes, which Branch? _____  |       |       |

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



**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 Radiologist 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: \_\_\_\_\_

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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 Radiologist Assistant License Number: \_\_\_\_\_

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

**RADIOLOGIST 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 Radiologist 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 Radiologist Assistant: \_\_\_\_\_**

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



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (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 Radiation Practitioner)*

do affirm that I have read the Radiologist Assistant Act, Arkansas Code 17-106-101, *et seq.*, Medical Practices Act and the Rules and Regulation 29 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 Radiologist Assistant)*

Signed: \_\_\_\_\_  
*(Supervising Radiation Practitioner Signature)*

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

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



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## VERIFICATION OF RADIOLOGIST ASSISTANT EDUCATION

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

Street \_\_\_\_\_

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

I, \_\_\_\_\_, Radiologist 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 **Radiologist Assistant Education**.

I hereby authorize \_\_\_\_\_, its staff, or representative to provide the Arkansas State Medical  
*(Name of Radiologist 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, Radiologist Assistant Licensing, 2100 Riverfront Drive, Little Rock, Arkansas 72202-1435. 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 RADIOLOGIST ASSISTANT EDUCATION ONLY. Please provide exact dates.**

The following section must be completed by the dean or registrar of the Radiologist 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 Radiologist 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

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



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## VERIFICATION OF HOSPITAL/CLINIC RADIOLOGIST ASSISTANT AFFILIATION

Name of Office \_\_\_\_\_

Street \_\_\_\_\_

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

I, \_\_\_\_\_, Radiologist Assistant, have applied for a license to work 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, Radiologist Assistant Licensing, 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 Radiologist 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 Radiologist 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



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

## PROFESSIONAL LIABILITY VERIFICATION

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

Street \_\_\_\_\_

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

I, \_\_\_\_\_, Radiologist Assistant have applied for a license to practice medicine in  
*(Print full name)*

the state of Arkansas. As part of the application process, the Arkansas State Medical Board requires verification of my current **Liability Insurance**.

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

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

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

### For verification of PROFESSIONAL LIABILITY

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

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

\_\_\_\_\_ *(Carrier)* \_\_\_\_\_ *(Certificate or Policy Number)* \_\_\_\_\_ *(Policy Amount)*

Dates of Coverage \_\_\_\_\_ to \_\_\_\_\_  
MO/DAY/YR MO/DAY/YR

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

YES NO

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

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

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

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

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

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

Title \_\_\_\_\_



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## VERIFICATION OF LICENSURE

I, \_\_\_\_\_, Radiologist Assistant, hereby authorize and request the state licensing 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 Radiologist 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 licensing 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
-------------	----------------	---

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: (    ) _____



# ARKANSAS STATE MEDICAL BOARD

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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 Training 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.

<http://www.archives.gov/veterans/military-service-records/get-service-records.html>



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## RADIOLOGIST ASSISTANT SUPERVISING RADIATION PRACTITIONER APPLICATION

1. Radiologist Assistant's Name: \_\_\_\_\_
  
2. Supervising Radiation Practitioner's Name: \_\_\_\_\_ License #: \_\_\_\_\_
  
3. Supervising Radiation Practitioner's Address: \_\_\_\_\_
  
4. Supervising Radiation Practitioner's Phone Numbers: Office: \_\_\_\_\_ Home: \_\_\_\_\_ Fax: \_\_\_\_\_
  
5. Supervising Radiation Practitioner's Medical School, Address and Date of Graduation: \_\_\_\_\_  
\_\_\_\_\_
  
6. Supervising Radiation Practitioner's Specialty: \_\_\_\_\_ Board Certified? \_\_\_ Yes \_\_\_ No
  
7. Type or Scope of Practice of Supervising Radiation Practitioner: \_\_\_\_\_
  - (a) Services Rendered: \_\_\_\_\_  
\_\_\_\_\_
  - (b) Area or Geographic Range of Radiology Practitioner: \_\_\_\_\_  
\_\_\_\_\_
  - (c) Type of Facility: Office \_\_\_\_\_ Clinic \_\_\_\_\_ Hospital \_\_\_\_\_ Other \_\_\_\_\_
  
8. Name, Address and License Number of the Alternate Supervising Radiology Practitioner who will supervise Radiologist Assistant in your absence, and a description of when the Alternate Supervising Radiology Practitioner will be utilized:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attach additional sheets, as necessary

9. List any Radiology Assistants or Radiology Practitioner Assistants you currently provide supervision to. Include the RA's name and license number with designation of your supervision, i.e., Supervising Radiation Practitioner or Alternate Supervising Radiology Practitioner:

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

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

\_\_\_\_\_  
(Signature of Supervising Radiation Practitioner)

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. Copy of the Supervising Radiation Practitioner's DEA certificate.
3. Copy of the Supervising Radiation Practitioner's current liability insurance certificate.
4. Signed practice specific document.

**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 72202-1435 (501) 296-1802 FAX: (501) 296-1805

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

## PRACTICE SPECIFIC DOCUMENT

The Practice Specific Document which is being submitted has not changed from my last approval by the ASMB Radiologist Assistant Advisory Committee with the exception of changing my Alternate Supervising Radiologist.

Signed: \_\_\_\_\_  
(Radiologist Assistant)

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

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

Name of Alternate Supervising Radiologist: \_\_\_\_\_

**THIS IS A REQUIREMENT FOR APPROVAL WHEN ADDING OR CHANGING AN ALTERNATE SUPERVISING RADIOLOGY PRACTITIONER. YOU MUST COMPLETE THIS FORM AND RETURN IT TO:**

Arkansas State Medical Board  
Attn: Radiologist Assistant Licensing  
2100 Riverfront Drive  
Little Rock, AR 72202-1435



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802 FAX: (501) 296-1805

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## RADIOLOGIST ASSISTANT ALTERNATE SUPERVISING RADIOLOGIST APPLICATION

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

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

\_\_\_\_\_  
(Signature of Supervising Radiation Practitioner)

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

\_\_\_\_\_  
(Signature of Alternate Supervising Radiologist)

**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 Alternate Supervising Radiologist Scope of Practice Statement.**
- 3. Signed Practice Specific Document.**

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



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

## ALTERNATE SUPERVISING RADIOLOGIST SCOPE OF PRACTICE STATEMENT

### Regulation 29

The Supervising Radiation Practitioner and Alternate Supervising Radiologist must have privileges to perform the procedure for which he/she is supervising the RA. If an invasive procedure, the radiation practitioner must satisfy, at a minimum, the same educational and experience requirements as the RA or RPA.

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

**Signed:** \_\_\_\_\_  
(Alternate Supervising Radiologist Signature)

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

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

**Name of Radiologist Assistant:** \_\_\_\_\_

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

Arkansas State Medical Board  
Attn: Radiologist Assistant Licensing  
2100 Riverfront Drive  
Little Rock, AR 72202-1435



# ARKANSAS STATE MEDICAL BOARD

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## ARKANSAS RULES AND REGULATIONS AFFIDAVIT

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

do affirm that I have read the Medical Practices Act, Arkansas Code 17-106-101, *et seq.*, and the Rules and Regulation 29 of the Arkansas State Medical Board.

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

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

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



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802 FAX: (501) 296-1805

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

## PRACTICE SPECIFIC DOCUMENT

The Practice Specific Document which is being submitted has not changed from my last approval by the ASMB Radiologist Assistant Advisory Committee with the exception of changing my Alternate Supervising Radiologist.

Signed: \_\_\_\_\_  
(Radiologist Assistant)

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

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

Name of Alternate Supervising Radiologist: \_\_\_\_\_

**THIS IS A REQUIREMENT FOR APPROVAL WHEN ADDING OR CHANGING AN ALTERNATE SUPERVISING RADIOLOGY PRACTITIONER. YOU MUST COMPLETE THIS FORM AND RETURN IT TO:**

Arkansas State Medical Board  
Attn: Radiologist Assistant Licensing  
2100 Riverfront Drive  
Little Rock, AR 72202-1435

**Arkansas State Medical Board  
2100 Riverfront Drive  
Little Rock, AR 72202  
Phone: (501) 296-1802  
Fax: (501) 296-1805**

### **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. Please provide the Board, in writing, with the name of the person, other than yourself, that will be working with you to complete your file. Until written notification of the other contact has been received, the licensing 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 to the person listed below:**

---

*Print Full Name of Representative*

---

*Email Address of Representative*

---

*Print Full Name of Applicant*

---

*Signature of Applicant*

---

*Date Signed*

Note: This document must be completed and returned with your application. Information will not be release to anyone other than yourself without this written authorization.
---

REGULATION 29 GOVERNING  
RADIOLOGY ASSISTANTS/RADIOLOGY PRACTITIONER ASSISTANTS

I. DEFINITIONS

- A. Licensed Practitioner means a person licensed to practice medicine, dentistry, podiatry, chiropractic, osteopathic, or optometry in the State of Arkansas;
- B. Radiation Practitioner means a licensed practitioner who has completed a residency in radiology, nuclear medicine, or radiation oncology, AND is certified by the American Board of Radiology, the American Osteopathic Board of Radiology, or the American Board of Nuclear Medicine or its equivalent;
- C. Radiologist Assistant (RA) or Radiology Practitioner Assistant (RPA) a person other than a licensed practitioner, who has specific qualifications, education, certification and responsibilities as recognized by the Arkansas State Medical Board and who has been issued a license to perform certain functions under the supervision of Licensed Radiation Practitioner;
- D. Supervising Radiation Practitioner means a radiation practitioner using the services of RA or RPA and is responsible for the professional activities and services of the RA or RPA under these Rules and Regulations;
- E. Alternate Supervising Radiologist means a radiation practitioner other than the supervising radiologist who is responsible for the supervision of RA or RPA for specific procedures in accordance with all Rules and Regulations applicable to the supervising radiation practitioner;
- F. Personal Supervision means the supervising and/or alternate supervising radiation practitioner must be in attendance in the room with the RA or RPA during the performance of the procedure or task;
- G. Direct Supervision means the supervising and/or alternate supervising radiation practitioner and/or radiologist must be present in the facility and immediately available to furnish assistance and direction to the RA or RPA during the performance of the procedure or task. The radiation practitioner is not required to be present in the room during the performance of the procedure or task;
- H. General Supervision means the procedure is furnished under the supervising and/or alternate supervising radiation practitioner's overall direction and control, but the practitioner is not required to be in the same room or facility with the RA or RPA during the performance of the procedure or task;

## II. REQUIREMENTS

The Radiologist Assistant (RA) and the Radiology Practitioner Assistant (RPA) must obtain a permit from the Arkansas State Medical Board to practice in the State of Arkansas, in order to obtain said permit the RA or RPA must comply with the following:

- A. Complete and submit an application and provide such information as the Board requires.
- B. Provide proof of successfully passing the Registered Radiologist Assistant examination by the American Registry of Radiologic Technologists, or provide proof of licensure in Arkansas by 2007 as a RA or RPA through the Division of Ionizing Radiation at the Arkansas State Department of Health.
- C. Be at least 18 years of age.
- D. Provide the names and signatures of the supervising and alternate supervising radiation practitioners licensed to practice in the State of Arkansas who agree to supervision of the RA or RPA under the terms of these Rules and Regulations.
- E. Provide a practice-specific document delineating the specific procedures and tasks to be performed by the RA or RPA in each facility utilized, including the level of supervision to be provided by the supervising licensed radiation practitioners.
- F. Pay a licensure fee of \$75.00 to the Board with the application for the initial permit. The supervising and alternate supervising radiation practitioners must sign the application form that they have read the Rules and Regulations and will abide by same, including disciplinary actions pertaining to the RA or RPA and themselves.
- G. Pay a renewal fee of \$50.00 with the annual renewal form for a permit and a copy of the practice privileges for each facility where the procedures are performed. The supervising and alternate supervising radiation practitioners must sign the renewal form that they have read the Rules and Regulations and will abide by same, including disciplinary actions pertaining to the RA or RPA and themselves.
- H. A request must be submitted for Board approval of any changes in supervising or alternate supervising radiation practitioners, and for any changes to the practice-specific document delineating the specific procedures and tasks to be performed by the RA or RPA in each facility utilized, including the level of supervision to be provided by the supervising licensed radiation practitioner(s).

### III. ROLES AND RESPONSIBILITIES

The RA or RPA may perform the tasks and functions as approved by the Board AND for which practice privileges have been secured at each facility where the procedure is performed.

Prescriptive authority for medications and images interpretation are expressly prohibited. Initial observation of the images by the RA and RPA may be communicated only to the supervising radiation practitioner. The RA and RPA may communicate the radiologist's interpretation to other care providers.

### IV. THE PRACTICE-SPECIFIC DOCUMENT

The practice-specific document is to be completed and signed by the RA or RPA and the supervising licensed radiation practitioner supervisor. The practice-specific document must be accepted and approved by the Arkansas State Medical Board prior to the licensure of the RA or RPA. Any change in the practice-specific document shall include the following:

- A. Procedures or tasks to be performed by the RA or RPA with the level of supervision to be provided by the licensed practitioner(s). All invasive procedures listed require a minimum level of direct supervision.
- B. Name and address of facility where the procedure(s) will be performed.
- C. The name of the alternate supervising licensed radiation practitioner(s).

### V. SUPERVISION

The radiation practitioners assume full responsibility for the actions of the RA and RPA. If there is any uncertainty regarding supervision of the Ra and RPA, the designated supervising radiation practitioner has ultimate responsibility.

Supervising and alternate supervising radiation practitioners must have the privileges to perform the procedures for which he/she is supervising for the RA and RPA. If it is an invasive procedure, the radiation practitioners must satisfy, at a minimum, the same educational and experience requirements as the RA or RPA.

All invasive procedures require a minimum level of direct supervision, and conscious sedation requires personal supervision by the radiation practitioner.

### VI. DISCIPLINARY ACTION

An RA and RPA must comply with the Medical Practices Act and the Rules and Regulations of the Board. Should the Board find that there is probable cause that in RA

or RPA has not complied with the Medical Practices Act and the Rules and Regulations of the Board, the Board will bring charges alleging the wrongful conduct and said disciplinary proceeding will comply with the Administrative Procedure Act of the State of Arkansas. At the conclusion of the disciplinary hearing, if the Board finds that the RA or RPA has violated the medical Practices Act or the Rules and Regulations of the Board, the Board may impose one or more of the following sanctions:

- A. Revoke the permit to practice in Arkansas as a RA or RPA.
- B. Suspend the permit for a period of time as determined by the Board.
- C. Issue a reprimand.
- D. Supervising radiation practitioners may be subject to disciplinary action by the Board if the RA or RPA violates the Medical Practices Act or the Rules and Regulations.

## VII. CONTINUING MEDICAL EDUCATION

- A. An RA or RPA with an active permit to practice in the State of Arkansas shall complete 6 credit hours per year of continuing medical education acceptable to the American Registry of Radiologic Technologists and/or the American Medical Association.
- B. If a person holding an active permit as an RA or RPA 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 permit as an RA or RPA in this state, the Board will include a form which requires the person holding the permit to certify by signature under penalty of perjury, and discipline by the Board, that he or she has met the stipulating continuing medical education requirements. In addition, the Board may randomly require the RA or RPA submitting such certification to demonstrate, prior to renewal of the permit, satisfaction of continuing medical education requirements stated in his or her certification.
- D. Continuing medical education records must be kept by the permit holder in an orderly manner. All records relative to continuing medical education must be maintained by the licensee for at least 3 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 upon request.
- E. Failure to complete continuing education hours as required, or failure to be able to produce records reflecting that one has completed the required minimal medical education hours shall be a violation and may result in the permit holder having his permit suspended and/or revoked.