



ARKANSAS STATE MEDICAL BOARD

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

www.armedicalboard.org

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: _____



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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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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 Supervising Radiologist Practitioner.

Signed: _____
(Radiologist Assistant)

Printed Name: _____

Date: _____

Name of Supervising Radiologist Practitioner: _____

**THIS IS A REQUIREMENT FOR APPROVAL WHEN ADDING OR CHANGING
A 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