



# ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

Phone (501) 296-1802 Fax (501) 296-1972 [www.armedicalboard.org](http://www.armedicalboard.org)

Emails with attachments must be sent in PDF format to [support@armedicalboard.org](mailto:support@armedicalboard.org)

## GRADUATE REGISTERED PHYSICIAN LICENSURE INFORMATION PACKET Medical Licensure & Centralized Credentials Verification Service

This packet contains all of the documents you will need to apply for a graduate registered physician license to practice medicine or osteopathy in Arkansas. This packet and each of its components are available on our web site, [www.armedicalboard.org](http://www.armedicalboard.org). If you received this packet from a source other than directly from the Arkansas State Medical Board or its official website, the application may be outdated or not an official version. Please be advised that outdated or unofficial versions of the application will not be accepted.

### \*\*\* IMPORTANT INFORMATION - PLEASE READ CAREFULLY \*\*\*

**ABANDONED APPLICATIONS.** Applications which are not complete after twelve (12) months will be classified as Abandoned and will be removed from our system. Further, pending applications will be listed as abandoned if the applicant does not communicate with the Board office for six (6) months. Abandoned files will be maintained for 30 days and then destroyed. No refunds will be given on abandoned/inactive applications.

**APPEARING BEFORE THE BOARD.** For your application to be placed on the Board Meeting agenda, it must be complete and all required documentation, including staff investigations, must be in this office. **THERE ARE NO EXCEPTIONS TO THIS POLICY.** Before being granted a license, you and your supervising physician will be required to make a personal appearance before the Board. You will be notified of the time and date of your appearance prior to the next scheduled Board Meeting.

**APPLICATION FEES.** The fee for graduate registered physician medical licensure is **\$500.00** (\$400 application fee plus \$100 Centralized Credentials Verification Service (CCVS) Assessment). Payment must be made by a single check or money order, made payable to *Arkansas State Medical Board*.

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

**ARKANSAS MEDICAL PRACTICES ACTS AND REGULATIONS.** The Arkansas Medical Practices Acts and Regulations must be read in their entirety prior to submitting an application for medical licensure to the Arkansas State Medical Board. You **MUST** complete the Rules & Regulations Affidavit located in this packet. The Medical Practices Act and Regulations can be viewed on our web site, [www.armedicalboard.org](http://www.armedicalboard.org).

**CENTRALIZED CREDENTIALS VERIFICATION SERVICE (CCVS).** Act 1410 of 2003 mandates physicians, clinics, hospitals and other healthcare organizations, managed care organizations, insurers or health maintenance organizations, and all other organizations credentialing physicians in Arkansas to use the CCVS to obtain credentialing information. The CCVS is an NCQA-certified credentials verification organization. When you apply for medical licensure in Arkansas, you are also enrolling with

the CCVS. There are no additional steps for you to take; your file will automatically be rolled over to CCVS once your license is approved. Participation in CCVS is not optional; it is state law.

**CHANGE OF ADDRESS.** Regulation 33 requires you to notify the Arkansas State Medical Board of any changes to your address within 30 days of such change. This includes your relocation to Arkansas, if applicable. A Change of Address form is available for download at our website, [www.armedicalboard.org](http://www.armedicalboard.org). THIS ADDRESS CHANGE MUST BE IN WRITING. The form must be fully complete, signed and dated. Once you are licensed, you may change your address online.

**CHECKING THE STATUS OF YOUR APPLICATION.** The Arkansas State Medical Board's required form of communication is an interactive Applicant Portal system that allows communication between us via the web. We have found that this system is a very effective communication tool and significantly reduces the time to licensure. You may access the Applicant Portal system from any computer at any time by visiting the Medical Board's web site at: <http://www.armedicalboard.org> once your access identification has been assigned.

When using the system, you will see a status bar which will show the percentage completed of your application process. Additional information regarding items that need your attention will be provided to you via a "Click here to respond" link on the "Applicant Portal Home" page. You will need to access your open items by choosing this link and providing a response to the items for which a response is requested.

This interactive system allows the licensing coordinators the time necessary to work your file as opposed to responding to numerous phone calls or e-mails from various interested parties checking on the status of your application. It also allows you to review the progress of your application at any time. You may wish to provide access to your application data to anyone whom you chose; however, once you allow this access, all communication in the system will be viewable. This means that all questions including health or disciplinary issues occurring in other states or institutions will also be viewable.

After all verifications have arrived, your file will be checked to ensure all time gaps have been accounted for in your time line. If they are not, you will be asked to document your activity during those specific times. Although this seems insignificant, it is very important to the Board and to its Centralized Credentials Verification Service (CCVS) certification. This step cannot be skipped.

Once all verifications have arrived and all time gaps filled, your application file will be presented for licensure consideration.

Due to the fact that the Arkansas Board has a state-mandated Credentials Verification Organization (CVO) which provides licensing information to all hospitals, insurance companies and other credentialing organizations, it is necessary for your current work history verifications to be re-verified every 120 days. This statement is to demonstrate to you the urgency to provide the information in a timely manner; otherwise the process is delayed during reverification.

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

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

Arkansas Code 17-95-306 states:

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

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

Upon receipt in this office of your completed application and fee, a CBC packet, including forms and instructions, will be sent to you for completion. You need to complete and return these forms at your earliest convenience. The Federal portion of this background check can take 4-6 weeks or more to process. ASMB will NOT accept a previously obtained criminal background check, regardless of how recently it was performed or what organization provides it. Payment for the CBC must be made by money order. Complete instructions will be provided in the CBC packet. It is imperative that the completed CBC packet be returned to the Board in a timely manner as failure to do so will delay licensure.

**FCVS.** The Federation Credentials Verification Service (FCVS) is a service provided by the Federation of State Medical Boards (FSMB). It is NCQA-certified for credentials verification and meets The Joint Commission's ten principles for a primary source verified credentials verification organization. FCVS staff uses primary sources to verify a physician's identity, education, training, and more, and creates a permanent profile of the verified credentials. The profile can be updated as needed throughout a physician's career and sent to boards and other entities without the need to verify each item again.

If you are using FCVS for credentials verification, do not provide a copy of your driver's license or passport, or a copy of any name change documents to the Board. Also, do not request examination scores/transcripts, verification of medical education and official transcript, or verification of postgraduate training to the Board. FCVS will provide these verified credentials to the Board on your behalf.

To use FCVS, visit <http://www.fsmb.org> and select "FCVS" from the Sign In menu in the upper right corner. Sign in and continue as directed. Complete an Initial Application if you are using FCVS for the first time. Complete a Subsequent Application if you need to update your existing FCVS profile. During the application process, designate your profile to be received by the Arkansas State Medical Board. The Board will not accept any FCVS profile with a Self designation. For assistance, contact FCVS through the messaging tool within FCVS, or call 888-275-3287 with your FCVS ID number.

**FOREIGN LANGUAGE DOCUMENTS.** All foreign language documents submitted by applicants and verification sources must be accompanied by a translation into English by an official translator. Documents received without an official translation will be returned to the applicant for forwarding to an official translator. The translated document must then be returned to the Board directly from the translator.

**PROCESSING TIME.** Processing delays are almost always attributable to lengthy work histories and delays in receiving the verification documents you request. If you have a history of malpractice, disciplinary action, impairment history, etc., additional time will be required for our investigation. Processing a permanent license application will take several weeks to complete. Please plan for this. Do not make commitments, purchase a home, or relocate your family before your license has been granted. Applications are processed in the order in which they are received in our office and in the order verification documents are provided. The board does NOT accelerate one applicant over another.

**SUBMITTING THE APPLICATION.** The application may NOT be submitted electronically or by fax, as we do require your original signature on the hard copy and all fees to be paid at submission.

**SUPERVISING PHYSICIAN.** By law, Graduate Registered Physicians are allowed to practice only under the direct supervision of a licensed physician. It is the responsibility of the GRP to keep this office informed of your current Supervising Physician.

**TEMPORARY PERMITS.** Temporary permits are not available to graduate registered physicians.

**TIME GAPS.** ALL time gaps of 30 days or more since the start of medical school must be explained in writing. You will be notified of any unexplained time gaps and asked to provide an explanation. To avoid processing delays, please include a separate signed explanation of any time gaps of 30 days or more with your original application. Failure to address time gaps may result in delay of licensure.

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

**VERIFICATIONS.** It is the policy of this board that ALL medical education and other activities since medical school be verified by the primary source prior to issuance of a permanent license. It is the applicant's responsibility to request verifications and to follow up with organizations to ensure verifications are returned. All verifications can be faxed or e-mailed unless specifically requested to be mailed. To fax, send to (501) 296-1972. TO E-MAIL, THE DOCUMENT MUST BE SENT AS AN ADOBE .PDF ATTACHMENT TO [support@armedicalboard.org](mailto:support@armedicalboard.org) with "Attn: Licensing" in the subject line. Note that if the attachments are not sent in this format and to this address, they will be stripped by the firewall and will not be received by the intended recipient.

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

**"YES" RESPONSES.** A "Yes" response in the attestation portion of the application does not mean your application will be denied. If you have responded "Yes" to any of these questions, additional time will be required for the gathering and assessment of pertinent information. You will be required to provide a separate, signed and complete explanation for each "Yes" response; you can expedite this process by including these with your original application. Failure to appropriately answer questions may result in an appearance before the Board for full licensure; disciplinary action; and/or denial of a license.

# REQUIREMENTS FOR GRADUATE REGISTERED PHYSICIAN LICENSE IN ARKANSAS

## **TO APPLY FOR A GRADUATE REGISTERED PHYSICIAN LICENSE, THE APPLICANT MUST:**

- Be at least twenty-one (21) years of age.
- Be of good moral character and have not been guilty of acts constituting unprofessional conduct, as defined in Arkansas Medical Practices Act Section 17-95-409.
- Complete a background check as defined in Arkansas Medical Practices Act Section 17-95-306.
- Be an Arkansas legal resident who has graduated from an accredited allopathic medical or osteopathic medical school and is not currently, nor has ever enrolled in an accredited PGT program.
- Be a citizen of the United States or legal resident alien who has graduated from an accredited Arkansas allopathic medical or Arkansas osteopathic medical school and is not currently, nor has ever enrolled in an accredited PGT program.
- Have taken and passed *within three attempts*, the first two steps of the USMLE or COMLEX.
- Present indisputable identification.
- Submit a completed application with payment of the \$400.00 application fee plus \$100.00 Centralized Credentials Verification Service (CCVS) Assessment (\$500.00 total).

## **LICENSURE IS BY CREDENTIALS:**

- Credentials must be verified from the originating source.

## **LICENSING EXAMINATIONS MEETING THE BOARD REQUIREMENTS ARE AS FOLLOWS:**

- M.D. – Successfully passed Step 1, Step 2 CK and Step 2 CS of the USMLE with no more than 3 attempts per Step.
  - Steps 1 and 2 must be passed within 2 years prior to applying, but not more than 2 years after graduating from medical school.
- D.O. – Successfully passed Level 1, Level 2 CE and Level 2 PE of the COMLEX with no more than 3 attempts per Level.
  - Levels 1 and 2 must be passed within 2 years prior to applying, but not more than 2 years after graduating from osteopathic medical school.

## **IF YOU ARE AN INTERNATIONAL MEDICAL GRADUATE, YOU MUST ALSO:**

- Have taken and received a Standard ECFMG (Educational Commission for Foreign Medical Graduates) certification.

## **ISSUANCE AND RENEWAL:**

- All Graduate Registered Physician applicants, along with their Supervising Physicians, must appear personally before the Arkansas State Medical Board for approval of the continuous supervising relationship and protocol.
- The Graduate Registered Physician license can be renewed two (2) times, allowing the licensee to be on this license for no more than three years.
  - The renewal fee will be the same amount as those of fully licensed physicians.
  - The Graduate Registered Physician license will expire one year from the date of issuance.
  - The Graduate Registered Physician will be scheduled to appear before the full Board 2 months prior to the expiration of the license.
  - The Supervising Physician will be required to appear with the licensee for the license to be renewed.
  - The Supervising Physician must provide verification of actual practice under the physician-drafted protocol.
- This license will go Inactive upon leaving the current employment and the licensee must notify the Board within 10 calendar days of any changes or additions in supervising physicians.
- The Graduate Registered Physician license will expire the day the licensee enters their PGT program.

## GRADUATE REGISTERED PHYSICIAN LICENSE APPLICATION CHECKLIST

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

### USE THE FOLLOWING ADDRESS FOR ALL DOCUMENT SUBMISSION:

ARKANSAS STATE MEDICAL BOARD  
ATTN: LICENSING DEPARTMENT  
1401 W. CAPITOL AVE., SUITE 340  
LITTLE ROCK, AR 72201

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

- Check or money order, made payable to *ASMB*, in the amount of \$500.00
- Application (4 pages), signed, with photo and certification by Notary Public. Signature must be original and must be made in black or dark blue ink. Stamped signatures, signatures by proxy and signatures by Power of Attorney are NOT accepted. Do not complete the application on front and back pages. Use one sided pages only.
- Signed and dated explanations for any “Yes” answers on Application, with applicable supporting documentation
- Completed Authorization and Release (form in packet)
- Completed Arkansas Medical Practices Acts and Rules and Regulations Affidavit (form in packet)
- Completed Secondary Contact Designation form, if applicable (form in packet)
- Curriculum Vitae (CV)
- \*\* Copy of Driver’s License or Passport, and proof of being a legal resident of the state of Arkansas
- \*\* Copy of name change documents, if applicable
- \*\* Copy of proof of citizenship, naturalization, visa, or work permit, if applicable (*if not born in the U.S.*)

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

- \*\* **Examination Scores/Transcripts:**  
USMLE: Go to <http://www.fsmb.org/transcripts.html> to request an “Examination and Board Action History Report”.  
COMLEX: Go to <http://www.nbome.org>
- Supervising Physician Application and Protocol (application included in packet – send to your Supervising Physician for completion)
- \*\* **Status Report of ECFMG Certification** - (*Foreign Medical Graduates only*)  
Go to <https://cvsonline2.ecfmq.org/> to request that this be electronically transmitted to the Board.

- \*\* Verification of Medical Education (form included in packet) and \*\*Official Transcript**  
Send a copy of this form to the Dean or Registrar of each medical school you attended.
  
- Verification of Employment - Medical** (form included in packet)  
Send to the Human Resources Department of every practice, clinic, and contract firm that employed you to perform patient care as a physician. The ASMB only requires the past 10 years of work history to be direct source verified; however, all work history since medical school must be listed on your application.
  
- Verification of Employment - Non-Medical** (form included in packet)  
Send to the Human Resources Department of every entity where you were employed since medical school, but did NOT perform patient care as a physician. This does not include hospitals unless you were employed without holding medical staff privileges. The ASMB only requires the past 10 years of work history to be direct source verified; however, all work history since medical school must be listed on your application.
  
- Physicians Health Committee Documents**  
If you are now being or have ever been monitored by a Physician Health Committee in any state or country, ask the director of that program to furnish a copy of your contract and a letter verifying your status. We must also have a PHC-specific Authorization & Release on file. If you are currently under a PHC contract, you must also contact the Arkansas Physicians' Health Committee:  
Arkansas Physicians' Health Committee  
Arkansas Medical Foundation  
10 Corporate Hill, Suite 150  
Little Rock, AR 72205  
(501) 224-9911

**\*\* Unless you are utilizing the FCVS**

## OVERVIEW AND HISTORY

**Overview:** Licensure in Arkansas serves a dual purpose in that, once licensed, the application also rolls specific information into the credentials verification organization (CVO) called the CCVS. Arkansas is unique in that no other state has a CVO attached to the state medical licensing authority. Once licensed in Arkansas, the CCVS will maintain a physician's credentialing information. Although this does not replace applications for credentialing privileges, it does alleviate the duplication of paperwork during the credentialing process. Any organization credentialing an Arkansas-licensed physician for Arkansas is required by state law to purchase specific information from the CCVS. An annual profile listing the information that will be made available, upon the physician's written authorization, to specific credentialing/healthcare organizations, is mailed to each physician with the annual state license renewal packet. By Act 1410 of 1999, physicians are required to review their printed information, complete and return the designated CCVS profile pages with any amendments/changes or additions legibly marked, adding a current copy of their curriculum vitae (CV), so new information in their CCVS file can be verified and updated in a timely manner.

The following information is released to credentialing/healthcare organizations only with the physician's written authorization:

- |  |   |
|--|---|
| 1. Education                             | 9. Specialty Board/Board Certification                                  |
| 2. Work History                          | 10. DEA (Federal/State)   |
| 3. License Information (AR & all others) | 11. Military History  |
| 4. Federation/Medicare/Medicaid* #'s     | 12. Current Malpractice Policy Info                                     |
| 5. Address & General Information*        | 13. Board History Excerpts  |
| 6. AMA/AOA Information                   | 14. Special Condition Alert (mental/emotional, physical, drug/alcohol)* |
| 7. Criminal Convictions Alert*           |   |
| 8. ECFMG Information (if applicable)     |   |

\*Reported and provided by the Physician.

The CCVS does NOT provide the following:

1. Competency information.
2. Criminal background check information, unless the Board takes action as a result of anything found in the background check.
3. National Practitioner Data Bank (NPDB) search info or details, unless action is taken by the Board as a result of anything found in the report. Only an "alert" indicator is provided to credentialing organizations. They must pull their own NPDB search report.
4. Peer Review or Recommendation information.
5. Continuing Medical Education (CME) breakdowns, other than the info found on the attestation. The Board requires and randomly audits for 20 annual CMEs but requires physicians to attest to completion between random audits.
6. Malpractice Claims History, other than information found on the attestations provided to the organizations. No claims history detail is provided.
7. Limitations on insurance coverage.

**Organization's Credentialing Packages:** The CCVS is certified by the National Committee for Quality Assurance (NCQA), which is the agency that certifies credentials verifications organizations (CVO) for managed care organizations and other insurers. Although the CCVS cannot obtain accreditation for The Joint Commission as a healthcare organization, the requirements are continually met to assist those organizations being surveyed under The Joint Commission standards. The information those organizations collect based on their individual medical staff bylaws, and not provided by the CCVS, complete the credentialing package when combined with the information provided by the CCVS.



The data in the ASMB web site is provided, controlled and maintained entirely by the Arkansas State Medical Board (ASMB) and is not modifiable by any outside source.

On-Line Arkansas License Verifications: The ASMB provides current data extracted from the ASMB's database and constitutes a primary source verification, whether from the free public site or the secure site for detailed verifications.

Board Actions/Notices: Any action or a physician's license is posted to the Board's website under BOARD NOTICES as soon as the action is made and can be accessed by the public at no charge.

## PRIMARY SOURCE LINKS

CONTACT THE APPLICABLE ORGANIZATIONS' WEB SITES TO REQUEST THAT THEY SEND THE REQUIRED VERIFICATIONS TO:

**Arkansas State Medical Board  
Attn: Licensure Department  
1401 W. Capitol Ave., Suite 340  
Little Rock, AR 72201**



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



Federation of State Medical Boards  
Request USMLE, FLEX, SPEX Transcripts  
<http://www.fsmb.org/transcripts.html>



Federation of State Medical Boards  
Request FCVS  
<http://www.fsmb.org/licensure/fcvs>



National Board of Medical Examiners  
Request Score Document  
<http://examinee.nbme.org/interactive>



National Board of Osteopathic Medical Examiners  
Request NBOME, COMLEX, CONVEX Transcripts  
<http://www.nbome.org>



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



National Personnel Records Center  
Request Military Service Records  
<http://www.archives.gov/veterans/military-service-records/>

# INSTRUCTIONS FOR COMPLETING APPLICATION FORM

1. READ ALL INSTRUCTIONS.
2. Type or print legibly in dark blue or black ink all application documents. (one sided only)
3. Provide exact dates (mm/dd/yyyy) whenever possible.
4. ANSWER ALL QUESTIONS/SECTIONS, even if your answer is "n/a," "Not Applicable," or "None."
5. Give careful thought to each question before answering. Remember, you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in Part III of the application, you must attach a signed and dated explanation.
7. Failure to answer all questions completely and accurately, or the omission or falsification of information, may be cause for denial of your application or disciplinary action if you are subsequently granted a license. WHEN IN DOUBT, DISCLOSE AND EXPLAIN ALL INFORMATION.
8. All signatures must be the applicant's; stamped signatures, signatures by proxy, and signatures by power of attorney are NOT accepted.

Indicate if you will be utilizing the Federation of State Medical Board's FCVS for your Arkansas license.

Indicate if you are a current or former member of the United States military or are the spouse of a current or former member of the United States military.

## Type of Graduate Registered Physician License

- ◆ Check *Medicine/Surgery (MD)* if you are a Medical Doctor, *Osteopathic Medicine/Surgery (DO)* if you are a Doctor of Osteopathy.

## PART I - PERSONAL IDENTIFICATION INFORMATION

### Question 1:

- a. Enter your legal name as listed on your driver's license, including any applicable suffix (Jr., III, etc.) and your degree (M.D. or D.O.).
- b. Enter any other names you have used in the past, including maiden name, married names, and any name which may be found in past education and employment records. *If your name has changed for any reason (marriage, divorce, adoption, naturalization, etc.), you must submit a copy of the pertinent legal document.*

### Question 2:

- a. Enter your social security number to be used for identification.
- b. Enter your driver's license number and the state in which it was issued.
- c. Check either Male or Female.
- d. Enter your date of birth in mm/dd/yyyy format.

### Question 3:

- a. Enter your place of birth (city and state, or city and country).
- b. Enter the name of the country in which you hold citizenship. If you are a U.S. citizen, enter "U.S.A." *If you are a U.S. citizen born in a foreign country, you must submit proof of citizenship.*
- c. Indicate your immigration status. If you are a U.S. citizen, enter "n/a." *If you are not a U.S. citizen, you must submit a copy of your current visa or work permit.*
- d. Indicate how long you have lived in the U.S. If you are a U.S. citizen, enter "n/a."
- e. Indicate your ethnicity by checking the appropriate box.
- f. Indicate your race by checking the appropriate box.

### Question 4 (Both addresses must be completed even if they are the same):

- a. Enter your Public mailing address. **This field is required.** This address appears on all printed reports, bulk data listings, the Online Directory and the free, online license verification system. It is also available to the general public under Freedom of Information (FOI),

and all other reports available to the credentialing organizations utilizing the ASMB website for license and/or credentials verification.

- b. Enter your Private mailing address. **This field is required.** The Private address is used to send renewal reminders, direct and confidential communication from the Board and the Board's quarterly Newsletter. It is NOT available to the public under FOI unless you also use this address as your public address.
- c-f. Enter your private, work, fax, and mobile phone numbers in the appropriate spaces.
- g. Enter your personal e-mail address. **Your personal e-mail address is required.** This is the e-mail address through which you will receive automated system messages as to the status of your application. You may also receive private and confidential e-mails for clarification purposes from the licensing staff. This is NOT your primary contact's e-mail address or your institutional e-mail address, as this e-mail address will carry over towards the required online renewal setup.

### Question 5:

Enter the name and address of the hospital, clinic, group or private practice where you intend to practice.

### Question 6:

- a. Enter your National Provider Identification (NPI) number. If you do not have an NPI number yet, enter "None," "Pending," etc.
- b. If you intend to accept Medicaid and/or Medicare patients in Arkansas, check either or both boxes, or whichever box is applicable.

## PART II - EDUCATION

### Question 7:

- a. Enter the full name of the first medical school you attended.
- b. Enter the country in which this medical school is/was located.
- c. Enter the mailing address of this medical school.
- d. Enter the date you started attending this medical school
- e. Enter the date you left this medical school. *If you completed your medical school education in more or less than the usual length, you must submit a separate, signed and dated explanation of the circumstances.*
- f. Check "Yes" if you graduated from this medical school, "No" if you did not. *If you left this medical school before completion, you must submit a separate, signed and dated explanation of the circumstances.*
- g. Check the appropriate degree. International Medical Graduates that earned an "M.B.B.S." or other equivalent to an "M.D." degree should check "M.D."

Complete the top portion of the \*\* "Verification of Medical/Osteopathic Education" form and send with any necessary fees to the medical school for completion. In addition to the form, the medical school must provide an official transcript directly to this office.

**Question 8:**

- a. Enter the name of the Exam Series and Step.
- b. Enter the total number of times you took this examination.
- c. Enter the number of times you failed this examination. *If you failed this examination, even once, you must submit a separate, signed and dated explanation of the circumstances.*
- d. Enter the date on which you passed this examination.

\*\* For USMLE, visit the Federation of State Medical Boards' website (<http://www.fsmb.org/transcripts.html>) to request your USMLE transcript be sent directly to this office.

\*\* For COMLEX, visit the National Board of Osteopathic Medical Examiners website (<http://nbome.org>) to request your COMLEX transcript be sent directly to this office.

**Question 9:**

- a. If you are an International Medical Graduate, check "Yes" if you hold an ECFMG certification, "No" if you have not. If you are not an International Medical Graduate, check "No." *If you are an International Medical Graduate but do not have an ECFMG certificate, you must submit a separate, signed and dated explanation of the circumstances.*
- b. Enter your ECFMG Certificate Number.
- c. Enter the date your ECFMG Certificate was issued.

\*\* Visit the ECFMG website (<https://cvsonline2.ecfmg.org>) to request a Status Report of ECFMG Certification be sent directly to this office.

**Question 10:**

**Include all professional activities, institutional affiliations or places of employment since the start of medical school. This includes hospitals, employment, military assignments, and government agencies. Also list leaves of absence since the beginning of medical school. DO NOT ENTER "SEE CV;" THIS SECTION MUST BE COMPLETED EVEN THOUGH YOU ARE SENDING YOUR CURRICULUM VITAE.**

- a. Enter the start date of the activity.
- b. Enter the end date of the activity. If current, enter "Current."
- c. Select the type of affiliation.
- d. Enter the full name of the facility/institution.
- e. Enter the full address of the facility/institution. If the facility is closed, enter the city and state/country and "Facility closed."
- f. Enter your title/position.

*Additional sheets may be attached.*

*For medical employers, complete the top portion of the "Verification of Employment (Medical)" form and send it with any necessary fees to each employer or contract firm. Forms must be returned directly to this office from the sources.*

*For non-medical employers, complete the top portion of the "Verification of Employment (Non-Medical)" form and send it with any necessary fees to each employer. Forms must be returned directly to this office from the sources.*

**PART III - ATTESTATION QUESTIONS**

**QUESTIONS 11-19:**

*For each "Yes" response to questions 11 through 19, you must provide a separate, signed and dated statement giving full details, including date, location, type of action, organization or parties involved, and specific circumstances. If you are not sure how to respond to a question, it is best to disclose all information and provide an explanation. Failure to answer these questions accurately may result in disciplinary action or denial of license application.*

*If, during the application process, you become aware of any investigation, action, or other circumstance relating to questions asked in this section, you are required to report it to this office.*

**FOR QUESTION 13, be advised that you must answer "Yes" to this question even if your records have been sealed, expunged or pardoned.** *If you answer "Yes," you must provide a signed and dated statement setting forth the explanation for each charge, arrest, or conviction no matter the date of the occurrence. If you were convicted, your statement must indicate whether you were paroled or placed on probation and how probation was completed. If you answer "Yes," in addition to the signed and dated statement, you must also provide a copy of the original charging document (indictment, information, etc.), judgment or conviction for any charge, arrest or conviction within the past ten years and for any felony charge/conviction no matter the date of the occurrence.*

**FOR QUESTION 19, if you answer "Yes," your statement must include the name of each monitoring program you participated in, the dates of all monitoring contracts, and your current status with each program.** *Ask the Director of the monitoring program to furnish a letter verifying your status and copies of all contracts. You must sign and return to this office a "Physicians' Health Committee Authorization & Release" form, and contact the Arkansas Physicians' Health Committee:*

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

**PART IV - AFFIDAVIT OF APPLICANT**

*You must attach a signed and dated recent passport-style photo in the space provided. Applications received without a photo will be returned.*

*Sign the application in the presence of a Notary Public, swearing that you are the person referred to in the application and that all statements contained therein are true and correct. The Notary's date must match your signature date.*

**Confidentiality:** *The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.*

**\*\* Unless you are utilizing the FCVS**



# ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

Emails with attachments must be sent in PDF format to support@armedicalboard.org

Are you utilizing FCVS for your Arkansas license?  Yes  No

Are you a current or former member of the U.S. military or a spouse of a current or former member of the U.S. military?  Yes  No

## APPLICATION FOR GRADUATE REGISTERED PHYSICIAN IN ARKANSAS & Centralized Credentials Verification Service

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

### TYPE OF GRADUATE REGISTERED PHYSICIAN LICENSE YOU ARE APPLYING FOR (check one)

Medicine/Surgery (MD)  Osteopathic Medicine/Surgery (DO)

### PART I - PERSONAL IDENTIFICATION INFORMATION

1a. Full Legal Name (Last, First, Middle, Suffix, Degree)			
1b. Other Names Used (including Maiden Name)			
2a. Social Security Number	2b. Driver's License State & Number	2c. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	2d. Date of Birth (mm/dd/yyyy) / /
3a. Place of Birth		3b. Country of Citizenship	
3c. Immigration Status (if not U.S. citizen)		3d. How long have you been in the U.S.? (if not U.S. citizen)	
3e. Ethnicity <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic		3f. Race <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hawaiian/Pacific Islander	
4a. Public Address (Street, City, State, Zip Code)			
4b. Private Address (Street or PO Box, City, State, Zip Code)			
4c. Private Phone #	4d. Work Phone #	4e. Fax #	4f. Mobile Phone #
4g. Personal E-mail Address			
5. Intended Practice Location in Arkansas: Name and Address of Hospital, Clinic, Group or Private Practice			
6a. NPI Number	6b. Accept Medicaid/Medicare Patients? <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Neither <input type="checkbox"/> Unknown/Undecided		

#### FOR ASMB USE ONLY

Name _____	Application Received _____
License Number _____	Fees Received \$ _____
License Issued _____	Application Declined _____
Basis for License _____	PHIDNO _____

**PART II - EDUCATION****MEDICAL SCHOOL EDUCATION**

List all medical school(s) you attended (attach additional sheets if necessary). **If you attended more than one medical school, provide the reason you changed medical schools on a separate sheet of paper, signed and dated by you.**

7a. Institution Name			7b. Country of Medical School
7c. Mailing Address (Street Address, City, State/Country, Zip Code)			
7d. Start Date / /	7e. End Date / /	7f. Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	7g. Degree Awarded <input type="checkbox"/> M.D. (or foreign equivalent) <input type="checkbox"/> D.O. <input type="checkbox"/> None
7a. Institution Name			7b. Country of Medical School
7c. Mailing Address (Street Address, City, State/Country, Zip Code)			
7d. Start Date / /	7e. End Date / /	7f. Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	7g. Degree Awarded <input type="checkbox"/> M.D. (or foreign equivalent) <input type="checkbox"/> D.O. <input type="checkbox"/> None

**EXAMINATION HISTORY**

Please specify exam series USMLE OR COMLEX.

8a. Exam Series & Step	8b. Number of Attempts	8c. Number of times failed	8d. Date PASSED / /
8a. Exam Series & Step	8b. Number of Attempts	8c. Number of times failed	8d. Date PASSED / /
8a. Exam Series & Step	8b. Number of Attempts	8c. Number of times failed	8d. Date PASSED / /
8a. Exam Series & Step	8b. Number of Attempts	8c. Number of times failed	8d. Date PASSED / /
9a. If you are an International medical graduate, do you hold an ECFMG certification? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, you must provide a signed and dated explanation)		9b. ECFMG Certificate No.	9c. Date Issued / /

**WORK HISTORY**

Please provide a chronological listing of all medical and non-medical work history and other activities, including hospitals, military assignments, government agencies, time gaps and leaves of absence since the start of medical school. Do not include Medical School or Postgraduate Education/Training. **Do not write, "See CV;" you must complete this section AND attach your curriculum vitae. If none, enter, "N/A."**

10a. Date From / /	10b. Date To / /	10c. Type of Affiliation <input type="checkbox"/> Hospital <input type="checkbox"/> Military Assignment <input type="checkbox"/> Government Agency <input type="checkbox"/> Time Gap <input type="checkbox"/> Leave of Absence	
10d. Name of Institution/Facility			
10e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)			
10f. Title/Position			
10a. Date From / /	10b. Date To / /	10c. Type of Affiliation <input type="checkbox"/> Hospital <input type="checkbox"/> Military Assignment <input type="checkbox"/> Government Agency <input type="checkbox"/> Time Gap <input type="checkbox"/> Leave of Absence	
10d. Name of Institution/Facility			
10e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)			
10f. Title/Position			

## PART III – ATTESTATION QUESTIONS

### SPECIAL INSTRUCTIONS FOR QUESTIONS 11-19

- Please mark the appropriate box next to each question. Do not leave any questions blank.
- For each “Yes” response to questions 11-19, you must provide a separate, signed and dated statement giving full details including date, location, type of action, organization or parties involved, and specific circumstances. If you are not sure about how to respond to a question, it is best to disclose and provide an explanation.
- Failure to answer these questions accurately may result in disciplinary action or denial of license application.
- **Confidentiality:** The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a “Yes” answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.

11. Has your application for examination or licensure ever been rejected, denied or withdrawn? *If yes, explain.*  No  Yes
12. Has a medical education program or hospital ever initiated disciplinary procedures against you? *If yes, explain.*  No  Yes
13. Since the start of medical school, have you been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony (including DWI (Driving While Intoxicated) or DUI (Driving Under the Influence)? (NOTE: **You must answer “Yes” even if records, charges, or convictions have been pardoned, expunged, plead down, released, or sealed.**) *If yes, explain.*  No  Yes
14. Have you ever received a warning, reprimand, been placed on probation, disciplined or dismissed from any medical education program? *If yes, explain.*  No  Yes
15. Have you ever voluntarily or involuntarily left a training institution program before completing it? *If yes, explain.*  No  Yes
16. Have you ever had to discontinue a medical education program for any reason for a period longer than one (1) month? *If yes, explain.*  No  Yes
17. Since the age of 21, have you been, or are you currently, being treated for alcoholism or substance abuse in an inpatient or outpatient setting? *If yes, explain.*  No  Yes
- 17a. If Yes, was this the result of a medical education program action?  No  Yes
18. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine or to perform professional or medical staff duties in a competent, ethical, and profession manner? *If yes, explain.*  No  Yes
19. Are you currently being, or have you ever been monitored by a Physicians Health Committee in any state? *If yes, explain, and ask the Physicians Health Committee to send documentation of your status.*  No  Yes

**PART IV - AFFIDAVIT OF APPLICANT**

I, the undersigned applicant, after being duly sworn, hereby certify that I have read the complete application and know the full content thereof. I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true, correct, current, and complete to the best of my knowledge. I attest that I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy, and that said degree was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware. I certify that the photograph that appears below is a true likeness of me, taken within the past sixty (60) days. I understand that any falsification or misrepresentation of any item or response in this application, or any documentation supporting this application, even if submitted separately, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice medicine in the State of Arkansas.

AFFIX  
PASSPORT-STYLE  
PHOTOGRAPH  
HERE

\_\_\_\_\_  
**Applicant's Signature (in ink)**

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

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

*(must include the month, day and year signed)*

.....  
SUBSCRIBED AND SWORN TO before me, a Notary Public in and  
for the State of \_\_\_\_\_, this

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

*(Notary date must be the same as the applicant's signature date above)*

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
**Notary Signature**

*(Notary seal must be placed below the photograph at left)*

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





# ARKANSAS STATE MEDICAL BOARD

& CENTRALIZED CREDENTIALS VERIFICATION SERVICE

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

Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

Emails with attachments must be sent in PDF format to support@armedicalboard.org

## AUTHORIZATION AND RELEASE

To Whom It May Concern:

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

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

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

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

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

Signature of Physician: \_\_\_\_\_

*Dark Blue or Black Ink Only - No Signature Stamps*

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

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



# ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

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## **ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT**

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE ANNOTATED SECTIONS 17-95-101, et. seq., AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD.

---

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

---

*Physician's Signature (no rubber stamps)*

---

*Signature Date*

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



# ARKANSAS STATE MEDICAL BOARD

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## SECONDARY CONTACT DESIGNATION FORM

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

- This form is optional. If you do not choose to list a secondary contact designation, this form is not required.

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

---

*Print full name of Secondary Contact*

---

*Organization Name*

---

*E-mail address of Secondary Contact*

---

*Phone number of Secondary Contact*

---

*Print full name of Applicant*

---

*Signature of Applicant (no signature stamps)*

---

*Date Signed*

**If you desire to utilize a secondary contact, this document must be completed and returned with your initial application. Information regarding your licensure application will not be released to anyone other than you without this written authorization. If you choose to utilize a designated contact, that person will be copied on all correspondence sent from this office regarding your application.**



# ARKANSAS STATE MEDICAL BOARD

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Phone: (501) 296-1802 Fax: (501) 296-1972

Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: \_\_\_\_\_

## VERIFICATION OF MEDICAL/OSTEOPATHIC EDUCATION

### PART I – INSTITUTION NAME AND MAILING ADDRESS – **PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED**

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

### PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX-_____	Date of Birth (mm/dd/yyyy) / /
Other Names Used		Date of Graduation (mm/dd/yyyy) / /
<i>AUTHORIZATION &amp; RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.</i>		
Physician Signature		Date Signed (mm/dd/yyyy) / /

### PART III – VERIFICATION (TO BE COMPLETED BY MEDICAL/OSTEOPATHIC SCHOOL STAFF ONLY)

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

Name of Medical/Osteopathic School (if not correct above)		
Date Medical Education Began / /	Date of Medical Degree / /	Degree Awarded <input type="checkbox"/> M.D. (or foreign equivalent) <input type="checkbox"/> D.O. <input type="checkbox"/> Neither (did not complete)
If the physician did not complete his/her medical education at your institution, please provide explanation (use additional sheets if necessary).		
If medical education was completed in more or less than four (4) years, please provide explanation (use additional sheets if necessary).		
During this physician's medical education, was he/she ever investigated or disciplined by the school for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>[Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted or otherwise disciplined. If you respond "Yes" to this question, please provide a detailed explanation on a separate sheet, signed and dated by the person whose signature appears below.]</i>		

### PART IV - VERIFIED BY

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

**PLEASE RETURN THIS FORM WITH AN OFFICIAL TRANSCRIPT DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL**  
*(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)*



# ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

Phone: (501) 296-1802 Fax: (501) 296-1972

Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: \_\_\_\_\_

## VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) **PART I AND PART II TO BE FILLED OUT BY THE APPLICANT-REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)**

### PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: \_\_\_\_\_

ATTN: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

### PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX- ____ ____ ____ ____	Date of Birth (mm/dd/yyyy) / /
<i>AUTHORIZATION &amp; RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.</i>		
Physician Signature		Date Signed (mm/dd/yyyy) / /

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

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

Name of Employer (if not correct above)		
Employment Status <input type="checkbox"/> Current <input type="checkbox"/> Inactive <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other _____		
Date Employment Began / /	Date Employment Ended / /	<input type="checkbox"/> If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.		
Current or Most Recent Position/Title		
To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed). <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Unable to comment		

### PART IV - VERIFIED BY

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

**PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL (E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)**



# ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

Phone: (501) 296-1802 Fax: (501) 296-1972

Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: \_\_\_\_\_

## VERIFICATION OF EMPLOYMENT (Non-Medical)

(for verification of employment that did not involve patient care)

**PART 1 AND PART II TO BE FILLED OUT BY THE APPLICANT - REQUIRED FOR VERIFICATION TO BE ACCEPTED**

### PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: \_\_\_\_\_

ATTN: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

### PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX- ____ ____ ____	Date of Birth (mm/dd/yyyy) / /
<i>AUTHORIZATION &amp; RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.</i>		
Physician Signature		Date Signed (mm/dd/yyyy) / /

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

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

Name of Employer (if not correct above)		
Employment Status <input type="checkbox"/> Current <input type="checkbox"/> Inactive <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other _____		
Date Employment Began / /	Date Employment Ended / /	<input type="checkbox"/> If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.		
Current or Most Recent Position/Title		
To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed). <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Unable to comment		

### PART IV - VERIFIED BY

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

**PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL**  
*(E-mail attachments must be in PDF format and sent to [support@armedicalboard.org](mailto:support@armedicalboard.org) only)*



# ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

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

- Are you adding a new graduate registered physician? or
- Removing your graduate registered physician?

\_\_\_\_\_  
Name of former graduate registered physician

\_\_\_\_\_  
Date supervision ended (former supervising physician)

## GRADUATE REGISTERED SUPERVISING PHYSICIAN APPLICATION

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

### IMPORTANT INFORMATION

#### THE FOLLOWING ITEMS MUST BE INCLUDED WHEN SUBMITTING THIS APPLICATION:

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

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

### GRADUATE REGISTERED PHYSICIAN

\_\_\_\_\_  
Graduate Registered Physician's Name

### SUPERVISING PHYSICIAN INFORMATION

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

### FOR OFFICE USE ONLY

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

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

Date Denied \_\_\_\_\_

Fee Received : \$ \_\_\_\_\_

Fee Returned: \_\_\_\_\_

**GRADUATE REGISTERED PHYSICIANS CURRENTLY UNDER YOUR SUPERVISION**

Name of Graduate Registered Physician currently under your supervision	Arkansas License Number
Name of Graduate Registered Physician currently under your supervision	Arkansas License Number

---

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

Date Signed





# ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

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

Documents submitted by email must be sent in PDF format to support@armedicalboard.org

## **ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT**

**(Supervising Physician)**

**I AFFIRM THAT I HAVE READ THE ARKANSAS GRADUATE REGISTERED PHYSICIAN ACT, ARKANSAS CODE 17-95-901, *et seq.*, AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD INCLUDING REGULATION NUMBER 37.**

**I UNDERSTAND THAT I TAKE FULL RESPONSIBILITY FOR THE ACTIONS OF \_\_\_\_\_ WHILE HE/SHE IS UNDER MY SUPERVISION.**

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

\_\_\_\_\_  
*Supervising Physician's Signature (no rubber stamps)*

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

**ARKANSAS STATE MEDICAL BOARD  
ATTN: LICENSURE DEPARTMENT  
1401 WEST CAPITOL AVE, SUITE 340  
LITTLE ROCK, AR 72201**



# ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

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

- Are you adding a new graduate registered physician? or
- Removing your graduate registered physician?

\_\_\_\_\_  
Name of former graduate registered physician

\_\_\_\_\_  
Date supervision ended (former supervising physician)

## GRADUATE REGISTERED PHYSICIAN BACK-UP SUPERVISING PHYSICIAN APPLICATION

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

### IMPORTANT INFORMATION

#### THE FOLLOWING ITEMS MUST BE INCLUDED WHEN SUBMITTING THIS APPLICATION:

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

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

### GRADUATE REGISTERED PHYSICIAN

Graduate Registered Physician's Name

### BACK-UP SUPERVISING PHYSICIAN INFORMATION

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

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

Office Telephone Number	Office Fax Number	Home Telephone Number	Mobile Telephone #
-------------------------	-------------------	-----------------------	--------------------

E-mail Address	Specialty	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Type or Scope of Practice

Services Rendered

Type of Facility

Private Practice  Clinic  Hospital  Other \_\_\_\_\_

### PRIMARY SUPERVISING PHYSICIAN INFORMATION

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

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

**GRADUATE REGISTERED PHYSICIANS CURRENTLY UNDER YOUR SUPERVISION**

Name of Graduate Registered Physician currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	Arkansas License Number
Name of Graduate Registered Physician currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	Arkansas License Number
Name of Graduate Registered Physician currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	Arkansas License Number

\_\_\_\_\_  
Supervising Physician's Signature  
*(does not require Notary)*

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

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

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



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Documents submitted by email must be sent in PDF format to support@armedicalboard.org

## **ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT**

**(Back-up Supervising Physician)**

**I AFFIRM THAT I HAVE READ THE ARKANSAS GRADUATE REGISTERED PHYSICIAN ACT, ARKANSAS CODE 17-95-901, *et seq.*, AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD INCLUDING REGULATION NUMBER 37.**

**I UNDERSTAND THAT I TAKE FULL RESPONSIBILITY FOR THE ACTIONS OF \_\_\_\_\_ WHILE HE/SHE IS UNDER MY SUPERVISION.**

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

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

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

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## **BACK-UP SUPERVISING PHYSICIAN SCOPE OF PRACTICE STATEMENT**

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

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

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

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

\_\_\_\_\_  
*Graduate Registered Physician's Full Name*

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