ARKANSAS STATE MEDICAL BOARD
1401 West Capitol, Suite 340 • Little Rock, AR 72201 • (501) 296-1802
www.armedicalboard.org

Completed forms can be submitted via:
Email: covidtemplicense@armedicalboard.org (PDF format ONLY) or Fax: (501) 296-1972

Application For COVID-19 Emergency Temporary License

In an effort to assist with the COVID-19 health crisis, the Arkansas State Medical Board voted to grant emergency temporary licenses to Arkansas medical residents who have completed at least one year of postgraduate training and have the written recommendation of their program director. Verification of standard qualifications and identification will be gathered by the Board staff from the American Medical Association or American Osteopathic Association and the Federation of State Medical Boards websites.

The approved temporary license would be valid until 6/5/2020 and could then be renewed by the Board for an additional 2 months if necessary and will be inactivated once the Public Health Emergency declaration has been withdrawn or ended. All licensure fees wil be waived for this temporary license.

A letter from your Program Director stating that if necessary, you are competently trained to work independently, and a copy of your Driver's License must accompany this application.

PART I - PERSONAL IDENTIFICATION INFORMATION

1. Full Legal Name (Last, First, Middle, Suffix, Degree)	2. Other Names Used (including Maiden Name)		
3. Social Security Number	4. Driver's License State & Number	5. Gender ☐ Male ☐ Female	6. Date of Birth (mm/dd/yyyy) / /
7. Public Address (Street, City, State, Zip Code)			
8. Private Address (Street or PO Box, City, State, Zip Code)			
9. Private Phone #	10. Work Phone #	11. Fax #	12. Mobile Phone #
13. Personal E-mail Address	14. NPI Number		
15. Intended Practice Location in Arkansas: Name and Address of Hospital, Clinic or Group (if known)			

PART II - EDUCATION

MEDICAL SCHOOL EDUCATION

16. Institution Name	17. Country of Medical School
18. Mailing Address (Street Address, City, State/Country, Zip Code)	

19. Start Date / /	20. End Date / /	21. Degree Awarded ☐ M.D. (or foreign equivalent) ☐ D.O

POSTGRADUATE TRAINING

22. Institution Name			
23. Mailing Address (Street Address, City, State/Country, Zip Code)			
24. Start Date / /	25. Anticipated Completion Date / /	26. Specialty	27. Name of Program Director

I affirm that I will be providing health care services relating only to the Public Health Emergency concerning COVID-19 as declared by Arkansas Governor Asa Hutchinson. I understand that this license can be renewed at the discretion of the Arkansas State Medical Board and will be inactivated when the Public Health Emergency declaration has been withdrawn or ended.

Applicant Signature _____ Date _____

FOR ASMB USE ONLY

Name: _____ Application Received: _____

License Number: _____ PHID No.: _____

License Issued: _____ Basis for License: _____