ARKANSAS STATE MEDICAL BOARD

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

To whom it may concern:

The following is a list of <u>requirements</u> when submitting your application to the Arkansas State Medical Board for registration as a Surgical Technologist:

- ☐ **Check or money order, made payable to *ASMB*, in the amount of $1 (one); <u>Do *not* send cash.</u>**
- ☐ **Completed Application signed and certified by a 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.**
- ☐ **Documentation establishing method of registration**
  - **If seeking registration based on education and certification**
    - **Attach a copy of your diploma, certificate, or transcript showing successful completion of a nationally accredited surgical technology program OR submit a completed Verification of Education (form in packet); AND**
    - **Proof of NBSTSA or NCCT Certification (if you have taken and passed either examination)**
  - **If you are seeking registration based on military training**
    - **Provide proof of military training OR submit a completed Verification of Military Training (form in packet).**
  - **If you are seeking registration based on employment as a surgical technologist in the six (6) months prior to July 1, 2017**
    - **Provide a letter from your supervising surgeon or hospital verifying your employment OR submit a completed Verification of Employment (form in packet).**
    - ***Please note that if you are seeking registration based on this method, you must register with the Arkansas State Medical Board prior to March 31, 2020.***

The application and supporting documents are not acceptable electronically or by fax. The original application with supporting documentation must be received in order to be acceptable. Incomplete applications and/or documentation will not be accepted for processing. If you have any questions or concerns, you may contact this office by e-mail at licensemonitor@armedicalboard.org.

Sincerely,

Amy E. Embry

Amy E. Embry
Executive Director

Rev. 7/1/2023

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SURGICAL TECHNOLOGIST INFORMATION PACKET

This packet contains all of the documents you will need to complete registration in Arkansas. This packet and each of its components are available on our web site, www.armedicalboard.org. If you received this packet from a source other than 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 **

CHANGE OF ADDRESS. Rule 33 requires you to notify the Arkansas State Medical Board of any changes to your address within 30 days of such change. A change of address form is available for download at our website, www.armedicalboard.org. The form must be fully completed, signed and dated. Once you are registered and your online account has been established, you may change your address online.

COMPLETING THE APPLICATION. READ THE INSTRUCTIONS FOR EACH QUESTION BEFORE ANSWERING. The application may NOT be submitted electronically or by fax, as we do require your original signature on the hard copy. Please type or 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. Your application and documentation will be returned to you if they are incomplete. Pages must be printed on one side only. Two sided (front and back) applications will cause delays due to pages needing to be resubmitted.

REGISTRATION FEES. The fee for a Surgical Technologist registration is **$1** (one). Fees and all accompanying documentation must be included with your application at the time of submission. Payment may be made by check or money order payable to *ASMB*. **Do *not* send cash.**

REGISTRATION RENEWAL. Your Surgical Technologist registration, if granted, must be renewed annually on or before the last day of December. The renewal fee is $1 (one) per year. Your first renewal notification will be sent to you via e-mail 60 days prior to the renewal deadline. A follow up e-mail will be sent at approximately 45 days and a final e-mail notification will be sent 30 days prior to the renewal deadline. Failure to receive notice is NOT considered an excuse for nonrenewal. Failure to renew before midnight on the last day of December will cause your registration to automatically expire. If your registration expires, you will be assessed a $10.00 late fee to reinstate your registration.

*******REMINDER ***** It is illegal to present yourself as an active, registered Surgical Technologist in this state on an inactive or lapsed registration.**

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.

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 we have experienced in receiving mail that has been sent to us, we strongly recommend you utilize FedEx, UPS, or other *guaranteed* delivery service when sending your application or other documents to us.

VERIFICATIONS. All verifications and documents in support of your application must be submitted with your application. Incomplete applications will be returned. Verifications with original signatures are not required. The Board will accept copies of verifications; however, the verifications must be completed in their entirety in order to be accepted.

SURGICAL TECHNOLOGIST REQUIREMENTS FOR REGISTRATION IN ARKANSAS

TO APPLY FOR SURGICAL TECHNOLOGY REGISTRATION, A PRACTITIONER MUST:

(1) Meet one (1) of the following criteria:
   (A) Have satisfactorily completed a nationally accredited surgical technology program *and* hold a current credential as a certified surgical technologist from either the National Board of Surgical Technology and Surgical Assisting (NBSTSA) or the National Center for Competency Testing (NCCT).
   (B) Have successfully completed a surgical technologist training program during the person's service as a member of an branch of the United States Armed Forces; or
   (C) Have been employed to practice as a surgical technologist at any time within the six (6) months before July 1, 2017, if the applicant registers with the Arkansas State Medical Board on or before March 31, 2020.

(2) Submit a completed application, **all** required forms and a registration fee of $1 (one);

REGISTRATION APPLICATION REQUIREMENT:

- Documents supporting registration **must** be included with this application.

REGISTRATION EXAMINATIONS THAT MEET THE BOARD'S CERTIFICATION REQUIREMENTS:

- NBSTSA (National Board of Surgical Technology and Surgical Assisting)
- NCCT (National Center for Competency Testing)

DEFINITIONS:

(According to A.C.A. 17-95-1002 and Rule 40 of the Arkansas Medical Practices Act & Rules):

1. **(A) "Surgical Technologist"** means an individual who performs the skills and techniques of surgical technology under the direction and supervision of a licensed practitioner other than in the course of practicing as a licensed healthcare professional;"

   (B) "Surgical Technology" means surgical patient care that includes without limitation:
   (1) Preparing an operating room and a sterile field for surgical procedures by ensuring that surgical equipment is assembled and functioning properly and safely;
   (2) Preparing sterile supplies, instruments, and equipment using sterile technique;
   (3) Performing tasks in a sterile field, including;
      (a) Maintaining asepsis and a sterile operating field;
      (b) Passing supplies, equipment, or instruments according to the needs of the surgical team;
      (c) Sponging or suctioning an operative site;
      (d) Preparing and cutting suture material;
      (e) Providing irrigation solutions to the supervising physician and irrigating an operative site;
      (f) Providing drugs within the sterile field for administration by the supervising physician;
      (g) Handling specimens;
      (h) Holding retractors and other instruments;
      (i) Applying electrocautery to clamp on blood vessels;
      (j) Connecting drains to a suction apparatus;
      (k) Applying dressing to closed wounds; and
      (l) Performing counts of supplies such as sponges, needles, and instruments with the registered nurse circulator; and
   (4) The practice of surgical technology is a separate and distinct healthcare profession that does not include the practice of surgical assisting as performed by physician assistants, surgical assistants, or first assistants.

REGISTRATION 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
1401 WEST 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 $1 (one). **Do *not* send cash.**
- ❑ Completed Application signed and certified by a 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.
- ❑ Documentation supporting method of registration.

You are required to request the following documents from their primary sources, and these documents must be submitted with your application to the Arkansas State Medical Board.

- ❑ If seeking registration based on education and certification
    - Attach a copy of your diploma, certificate, or transcript showing successful completion of a nationally accredited surgical technology program **OR** submit a completed Verification of Education (form in packet);

      AND

    - Proof of Certification (if you have taken and passed either the NBSTSA or the NCCT examination). For verification of exam/certification, go to https://www.nbstsa.org/examination-results.html or https://www.ncctinc.com/General/VerifyCertification.aspx
- ❑ If you are seeking registration based on military training
    - Provide proof of military training **OR** submit a completed Verification of Military Training (form in packet).
- ❑ If you are seeking registration based on employment as a surgical technologist in the six (6) months prior to July 1, 2017
    - Provide a letter from your supervising surgeon or hospital verifying your employment **OR** submit a completed Verification of Employment (form in packet).

INSTRUCTIONS FOR COMPLETING REGISTRATION APPLICATION

1. READ ALL INSTRUCTIONS.
2. TYPE or PRINT in dark blue or black ink all application documents. (one sided documents 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. All signatures must be the applicant's; stamped signatures, signatures by proxy, and signatures by power of attorney are NOT accepted.

READ CAREFULLY!

Question 1: Name

a. Enter your legal name as listed on your driver's license, including any applicable suffix (Jr., Ill, etc.) and your degree (ST or FSA).

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.

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Question 2: Identification

a. Enter your social security number.

b. Check either Male or Female.

c. Enter your date of birth in mm/dd/yyyy format.

Question 3: Ethnicity/Race

a. Indicate your ethnicity by checking the appropriate box.

b. Indicate your race by checking the appropriate box.

Question 4: Contact Information (BOTH address sections 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, and the Online Directory. It is also available to the general public under Freedom of Information and all other reports available to the credentialing organizations utilizing the ASMB website for license, registration, 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. It is NOT available to the public under Freedom of Information 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. Your personal e-mail address should be entered here. **Your personal e-mail address is a requirement.** You may receive private and confidential e-mails for clarification purposes from the staff. This is NOT your institutional e-mail address, as this e-mail address will carry over to future renewals and communications.

Question 5: Intended Practice Location

a. Enter the name of the hospital, clinic, group or private practice where you will be practicing in Arkansas. If you have not yet found employment, enter "Unknown."

b. Enter the mailing address of the hospital, clinic, group or private practice where you will be practicing. If you have not yet found employment, enter "Unknown."

Part II – <u>Only complete the section which applies to your surgical technologist's qualification. It should not be necessary to complete all three sections.</u>

Question 6: Registration by Education/Examination

a. Enter the full name of the surgical technology school/ program where you completed your education.

b. Enter the mailing address of the school/program.

c. Enter the date you started attending the school/ program.

d. Enter the date you graduated from the school/ program.

e. Answer "Yes" if you graduated, "No" if you did not graduate.

f. Enter the degree you were awarded.

Attach a copy of your diploma, certificate or transcript showing successful completion of the Surgical Technology School or Program OR provide a Verification of Education (form in packet).

g. If you <u>have</u> taken and passed the NBSTSA exam, indicate "Yes". If you have <u>not</u> taken and passed the NBSTSA exam, indicate "No".

h. Indicate your NBSTSA certification number. If you are not certified, place "N/A" in this box.

i. If you <u>have</u> taken and passed the NCCT exam, indicate "Yes". If you have <u>not</u> taken and passed the NCCT exam, indicate "No".

j. Indicate your NCCT certification number. If you are not certified, place "N/A" in this box.

Attach verification of your certification. Please note – the ASMB accepts either the National Board of Surgical Technologists and Surgical Assisting Exam OR the National Center for Competency Testing Exam to meet the exam requirement. If you are registering based on the education and exam requirement, you must have passed either of the exams listed above prior to application.

Question 7: Registration by Military Training

a. Answer "Yes" if you received your Surgical Technologist training through the United States Armed Forces. Answer "No" if you did not.
b. Enter the branch in which you served.
c. Enter the date you started your training.
d. Enter the date you completed your training.
e. Enter the degree you were awarded.
f. Indicate if you are currently active duty.

Provide proof of military training OR submit a completed Verification of Military Training (form in packet).

Question 8: Registration by Surgical Technologist Employment

a. List a chronological, professional work history for the six (6) months prior to July 1, 2017.
b. Enter the mailing address of the employer.
c. Enter the date your employment began.
d. Enter the date your employment ended.
e. Enter your title or position with this employer.
f. Enter your current status with this employer (Active or Inactive).
g. Name of the Supervising Surgeon at this facility.
h. Address of the Supervising Surgeon (include the street, city, state and zip code).
i. Phone number of the Supervising Surgeon.

Attach letter from supervising physician or hospital confirming employment OR provide a Verification of Employment (form in packet).

Part III - Affidavit of Applicant (Signature Page):

Read the affidavit completely before signing. You must sign where indicated IN THE PRESENCE OF 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's date must match your signature date. *Applications received without the required Notary seal will be returned to the applicant for completion, thereby delaying the registration process.*

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APPLICATION FOR SURGICAL TECHNOLOGIST REGISTRATION

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. This office will not accept incomplete applications for processing

Please check the method by which you are registering:

- **Surgical Technology Program/Examination** ☐
- **Military Training** ☐
- **Surgical Technologist Employment** ☐

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. Gender	2c. Date of Birth (mm/dd/yyyy)
	☐ Male ☐ Female	/ /

3a. Ethnicity: ☐ Non-Hispanic ☐ Hispanic

3b. Race ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Black/African American ☐ White ☐ Hawaiian/Pacific Islander

4a. Public Address (Street, City, State, Zip Code)

4b. Private Address (Street, City, State, Zip Code)

4c. Private Phone #	4d. Work Phone #	4e. Fax #	4f. Mobile Phone #

4g. Personal E-mail Address

5a. Intended Practice Location in Arkansas: Full Name Hospital, Clinic, Group or Private Practice

5b. Mailing Address of Intended Practice Location (PO Box or Street, City, State, Zip Code)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Application Received: / / Fee Received: $ PHIDNO:

Registration # Registration Issued: / /

QUALIFICATIONS FOR REGISTRATION –

Complete ONLY the section by which you qualify for registration.

SURGICAL TECHNOLOGY PROGRAM/EXAMINATION

List surgical technology program you successfully completed. Attach a copy of your diploma, certificate or transcript showing successful completion or provide a completed Verification of Education (form in packet) *and* attach verification of your certification with your application (Either NBSTSA or NCCT).

6a. Full Name of Institution and Program			
6b. Mailing Address (Street Address, City, State, Zip Code)			
6c. Start Date / /	6d. End Date / /	6e. Completed? ☐ Yes ☐ No	6f. Degree/Certificate Awarded

6g. Have you passed the NBSTSA exam? ☐ Yes ☐ No	6h. NBSTSA Certificate #
6i. Have you passed the NCCT exam? ☐ Yes ☐ No	6j. NCCT Certificate #

MILITARY TRAINING

Provide proof of military training OR submit a completed Verification of Military Training (form in packet).

7a. Did you receive your Surgical Technologist training as a result of your service in the United States Armed Forces?
☐ Yes ☐ No

7b. Branch of Service:	7c. Start Date of Training / /	7d. End Date of Training / /	7e. Degree/Certificate Awarded

7f. Are you currently Active Duty? ☐ Yes ☐ No

SURGICAL TECHNOLOGIST EMPLOYMENT

Please provide a chronological listing of your work history as a surgical technologist <u>for the six months prior to July 1, 2017</u>. You may make copies if additional space is needed. Attach a letter from your supervising physician or hospital confirming employment OR provide a completed Verification of Employment (form in packet).

8a. Name of Institution/Facility/Employer			
8b. Mailing Address (Street or PO Box, City, State, Zip Code)			
8c. Date From / /	8d. Date To / /	8e. Title/Position	8f. Status
8g. Name of Supervising Surgeon:			
8h. Supervising Surgeon Address (Street, City, State and Zip):		8i. Supervising Surgeon Phone Number:	

8a. Name of Institution/Facility/Employer			
8b. Mailing Address (Street or PO Box, City, State, Zip Code)			
8c. Date From / /	8d. Date To / /	8e. Title/Position	8f. Status
8g. Name of Supervising Surgeon:			
8h. Supervising Surgeon Address (Street, City, State and Zip):		8i. Supervising Surgeon Phone Number:	

PART III - 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 understand that any falsification or misrepresentation of any item or response in this application, or any documentation supporting this application, is sufficient grounds for denying registration in the State of Arkansas.

_____

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 below the photograph at left)

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VERIFICATION OF SURGICAL TECHNOLOGIST EDUCATION

Parts I and II to be completed by the applicant.
Parts III and IV to be completed by the Dean, Registrar or Authorized Representative.
Completed form to be submitted by applicant with the application.

PART I – INSTITUTION NAME AND MAILING ADDRESS

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

PART II – APPLICANT INFORMATION (to be filled out by the applicant)

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) / /
AUTHORIZATION & 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.		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY DEAN, REGISTRAR or AUTHORIZED REPRESENTATIVE ONLY)

Please complete the information below (or your equivalent verification letter) and return to the applicant. Please provide exact dates if possible.

Name of Surgical Technologist School (if not correct above):		
Did the applicant successfully complete a surgical technology program? ☐ Yes ☐ No		
Date Education Began / /	Date Education Ended / /	Degree Awarded : ❒ None
Is this Surgical Technologist school nationally accredited?		❒ Yes ❒ No

PART IV - VERIFIED BY

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

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VERIFICATION OF SURGICAL TECHNOLOGIST MILITARY TRAINING

Parts I and II to be completed by the applicant.
Parts III and IV to be completed by Authorized Military Personnel.
Completed form to be submitted by the applicant with the application.

PART I – MILITARY NAME AND MAILING ADDRESS

Name of Duty Station: .....

ATTN: .....

Address Line 1: .....

Address Line 2: .....

City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION (to be filled out by the applicant)

Full Name (Last, First, Middle)	Social Security Number XXX – XX – _____	Date of Birth (mm/dd/yyyy) / /
AUTHORIZATION & 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.		
Applicant Signature		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY AUTHORIZED PERSONNEL ONLY)

Please complete the information below (or your equivalent verification letter) and provide to the applicant. Provide exact dates if possible.

Branch of Service in which Surgical Technologist Training Occurred:		
Did the applicant successfully complete the training program? ❒ Yes ❒ No		
Date Training Began / /	Date Training Completed / /	❒ If exact dates are not available, please check here.
Present Status: ❒ Active ❒ Inactive ❒ Leave of Absence ❒ Other _____		

PART IV - VERIFIED BY

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

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VERIFICATION OF SURGICAL TECHNOLOGIST EMPLOYMENT

(for verification of employment within six (6) months prior to July 1, 2017)

Parts I and II to be filled out by the applicant.
Parts III and IV to be completed by employer's authorized staff.
Completed form to be submitted by the applicant with the application.

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: .....

ATTN: .....

Address Line 1: .....

Address Line 2: .....

City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX-_____	Date of Birth (mm/dd/yyyy) / /
AUTHORIZATION & 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.		
Applicant Signature		Date Signed (mm/dd/yyyy) / /

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

Please complete the information below (or your equivalent verification letter) and return to the applicant. Please provide exact dates if possible.

Name of Employer (if not correct above):		
Was the applicant employed as a surgical technologist at any time within the six (6) months before July 1, 2017? ❒ Yes ❒ No		
Date Employment Began / /	Date Employment Ended / /	❒ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
Current or Most Recent Position/Title:		
Employment Status (check one): ❒ Current ❒ Inactive ❒ Leave of Absence ❒ Other _____		

PART IV - VERIFIED BY

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