ARKANSAS STATE MEDICAL BOARD

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Documents submitted by email must be sent in PDF format to support@armedicalboard.org

APPLICATION FOR PRE-APPROVAL OF RESPIRATORY THERAPY CONTINUING EDUCATION PROGRAM

1. **Type or print legibly (in dark blue or black ink).**
2. **All questions must be answered. Please do not write "see attached" as sections must be completed even if you are attaching documentation.**
3. **Completed application and documentation must be submitted to our office no later than one week prior to the program start date.**

Sponsor Agency/Institution		
Contact Person		
Mailing Address		Suite
City	State	Zip Code
Phone Number	Fax Number	E-mail Address
Program Dates: Starting:	Ending:	Program Name:
Location Address (if different than address above)		
City	State	Zip Code
Total Number of CEU's requested: (Count only instructional time. Do not include registration, breaks, practicing or testing time.)		
Can participants receive credit for partial attendance? Yes ☐ No ☐ If yes, describe how partial attendance will be verified and granted:		
Target Audience (Check all that apply): Clinician ☐ Manager/Supervisor ☐ Educator ☐ Nurse ☐ Physician ☐		
Teaching methods (Check all that apply): Lecture ☐ Textbook ☐ Workshop ☐ Clinical ☐ Collaborating ☐ Reading Journals/Articles ☐ Panel Discussion ☐ Charts ☐ Photographs ☐ Brainstorming ☐ Webcast ☐ Mock Presentation ☐ Evidence-Based Case Studies ☐ Webinar ☐ Self-Study ☐ Other: ☐ _____		
Name of Speaker(s)		
Learning Objectives		

PLEASE RETURN THIS FORM, COPY OF BROCHURE/AGENDA, EVALUATION FORM, AND APPLICABLE DOCUMENTATION 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, Attn: Mandi)