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

PHYSICIAN LICENSURE INFORMATION PACKET
Medical Licensure & Centralized Credentials Verification Service

This packet contains all of the documents you will need to apply for an unlimited license to practice medicine or osteopathy 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from a source other than directly from the Arkansas State Medical Board or its official website, the application may be outdated or not an official version. Please be advised that outdated or unofficial versions of the application will not be accepted.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. Prior to your application being 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, the following applicants may be required to make a personal appearance before the Board:

- Applicants who have disciplinary actions and/or impairment history
- Applicants with malpractice history (pending or settled)

If you are required to make a Board Appearance, you will be notified of the time and date of your appearance prior to the next scheduled Board Meeting. If your file contains no derogatory information, you may not be required to make a Board appearance. The Board reviews such files weekly. If the Board Members do not have any questions or concerns about your application or documentation, they will approve your application and your license will be issued on the following Thursday.

APPLICATION FEES. The fee for medical licensure is **$120** ($20 (twenty) 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*. If you meet the criteria as listed in A.C.A. 17-5-104 Fee waiver, you will need to include the Fee Waiver Form and supporting documentation with your application. There is an additional fee of $3 (three) if you are requesting a temporary license prior to full licensure.

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 RULES. The Arkansas Medical Practices Act and Rules must be read in their entirety prior to submitting an application for medical licensure to the Arkansas State Medical Board. You MUST complete the Medical Practices Act & Rules Affidavit located in this packet. The Medical Practices Act can be viewed on our web site, 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 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. Rule 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. THIS ADDRESS CHANGE MUST BE IN WRITING. The form must be fully completed, 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. Once your access identification has been assigned, 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.

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 Coordinator the time necessary to work your file as opposed to responding to numerous phone calls or emails 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 choose to provide access to your Applicant Portal to others; 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 ALL 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 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. 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. Two sided (front and back) applications will cause delays due to pages needing to be resubmitted.

CRIMINAL BACKGROUND CHECK. A.C.A 17-95-306 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.

CBC Notifications Form: Retain this page for your records.
CBC Privacy Right Statement: Sign and return with your application.

If you live outside of Arkansas:
Upon receipt in this office of your completed application and fee, a CBC packet, including forms and instructions, will be mailed to your private address for completion. You need to complete and return these forms at your earliest convenience as the Federal portion of this background check can take several 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 vital that the completed CBC packet be returned to the Board in a timely manner as failure to do so will delay licensure.

If you live in Arkansas:
Upon receipt in this office of your completed application and fee, an email will be sent to you from Support@armedicalboard.org regarding the necessary steps to be fingerprinted so your criminal background check can be conducted. It is vital that you follow these instructions as soon as possible to avoid delay in the licensing process.

Act 630 of 2021 was enacted which amended A.C.A. 12-12-1005. Beginning September 1, 2021, paper fingerprint cards (FD-258) are no longer being accepted by the Arkansas State Police for Arkansas residents and requires that background checks must be submitted by electronic means only:

(d)(1)A background check request for a non-criminal justice purpose that must be completed under state or federal law through the Division of Arkansas State Police shall be submitted to the division by electronic means through the Arkansas State Police Criminal Background Check System.

(2) This subsection does not apply to a submission originating outside the State of Arkansas.

Any licensing applicant living within the state of Arkansas will be required to submit their fingerprints electronically via Arkansas LiveScan. Do not do this step until you have received an acknowledgement email from this office. Failure to do so will result in an unsuccessful transmission of your fingerprints.

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 obtains primary-source verification of medical education, ACGME postgraduate training, examination history, board action history, board certification, ECFMG, identity 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.

** **NOTE** ** FCVS will not provide verification of non-ACGME training programs, which includes observerships, externships and foreign postgraduate training. Verification of non-ACGME training programs will require that you request the source to have documentation sent directly to this Board.

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, you will need to 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.

INTERNATIONAL MEDICAL GRADUATES. Act 498 of 2005 requires all medical license applicants who are internationally trained

A. to have completed at least three (3) years of postgraduate training in the United States;

B. to have completed at least three (3) years of postgraduate training outside the United States; passed the USMLE; have an ECFMG certification, completed one or more years of a fellowship in the United States, and be ABMS certified; *or*

C. have completed at least one (1) year of U.S. postgraduate training and currently be enrolled in an accredited postgraduate training program in Arkansas.

LICENSE RENEWAL. Your medical license, if granted, must be renewed annually on or before the last day of your birth month. There is no grace period. Your first renewal notification will be sent to you via email 60 days prior to the end of your birth month. A follow up email will be sent at approximately 45 days and a final email notification will be sent 30 days from the last day of your birth month. Failure to receive notice is NOT considered an excuse for nonrenewal. Failure to renew before midnight on the last day of your birth month will cause your license to automatically expire. If your license expires, you will be assessed a $50 late fee to reinstate your license. ********REMINDER ***** It is illegal to practice medicine in this State on an inactive or lapsed license or permit.**

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 multiple weeks to complete. Please plan for this. Do not make commitments, purchase a home, or relocate your family before your Arkansas Medical 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, as we do require your original signature on the hard copy and all fees to be paid at submission.

TEMPORARY PERMITS. You may request that a temporary permit be granted at the time you submit your application. Temporary permits can be issued ONLY when EVERY detail of the application process has been completed and is ready for Board approval. Temporary permits must be requested in writing and the required fee of $3 (three) must accompany your request. Temporary Permits expire

on the last day of the next regular Board Meeting, and can be extended only by submitting a written request and an additional $3 (three) fee. Issuance of a Temporary Permit does NOT guarantee that a permanent license will be granted (the licensure process is not complete until the Board votes and your license has officially been approved).

Please note that a temporary or permanent license, if approved, will not be issued until the file has completed the ENTIRE licensure process. The licensure process is dependent upon the needs of the file. The more proactive, interactive and reactive the applicant is during the licensure process, the faster the file can be completed.

TIME GAPS. Any 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, training, professional affiliations and other activities since the start date of 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 emailed unless specifically requested to be mailed. To fax, send to (501) 296-1972. TO EMAIL, THE DOCUMENT MUST BE SENT AS AN ADOBE .PDF ATTACHMENT TO 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. If the verification is sent by fax or email, request that the sender **not** send a hard copy my mail as duplicate verifications will delay the licensure process.

On February 4, 2016, the Arkansas State Medical Board reduced the verification of Work History and Hospital Privilege History to the last ten (10) years since graduation from medical school, unless circumstances call for additional work history verification. Although the collection of the verification information is now limited to ten (10) years, the applicant is still required to provide a work history that is inclusive of all history since the graduation from medical school on the application.

WITHDRAWN APPLICATIONS. Applications which are withdrawn by the applicant will be maintained for 30 days and then destroyed. No refunds are given on applications that are withdrawn. Withdrawing your application is NOT considered a negative event and would NOT be reported to the NPDB or the FSMB.

"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 MEDICAL LICENSURE IN ARKANSAS (M.D./D.O.)

TO APPLY FOR A MEDICAL LICENSE, A PHYSICIAN MUST:

- Be at least twenty-one (21) years of age
- 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 a graduate of an approved medical school and request your school provide a certified copy of your transcript directly to this board
- Have completed at least one (1) year of internship or residency in an ACGME approved program in the United States
- Have taken and passed *within three attempts* all steps of the USMLE (or other approved examination, such as FLEX, NBME, NBOME, COMLEX, LMCC or State Examination taken prior to 1975), as stated in Rule No. 14, which can be found in the Medical Practices Act.
- Present indisputable identification
- Submit a completed application with payment of the $20 application fee plus $100.00 Centralized Credentials Verification Service (CCVS) Assessment ($120 total).

LICENSURE IS BY CREDENTIALS:

- Credentials must be verified from the originating source.

LICENSING EXAMINATIONS MEETING THE BOARD REQUIREMENTS ARE AS FOLLOWS:

- FLEX, NBME, USMLE, NBOME; COMLEX, LMCC or State Board Examinations taken prior to 1975

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

- Have completed three (3) years of internship or residency in an ACGME approved program in the United States,
    - OR served three (3) years as an intern or resident in a postgraduate medical education program outside the United States, completed one (1) year or more of fellowship training in an ACGME approved program in the United States, AND received board certification by the American Board of Medical Specialties
    - OR have completed at least one (1) year of internship or residency in an ACGME approved program in the United States AND be currently enrolled in a postgraduate training program in Arkansas.
- Have taken and received a Standard ECFMG (Educational Commission for Foreign Medical Graduates) certification.
- Have taken and passed all steps of the USMLE with no more than three (3) attempts per step as stated in Rule No. 3, which can be found in the Medical Practices Act.

IF YOU ARE APPLYING FOR AN ACADEMIC LICENSE:

Please review A.C.A. § 17-95-412 in the Arkansas Medical Practices Act for all licensure and renewal requirement. The Arkansas Medical Practices Act can be viewed on our website, www.armedicalboard.org.

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: LICENSURE 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 (documents marked with an asterisk (*) are not required if you are utilizing the FCVS) – NOTE – FCVS will not provide verification of non-ACGME training programs.:

- ❑ Check or money order, made payable to *ASMB*, in the amount of $120 (plus an additional $3 (three) if requesting a temporary permit).
- ❑ Application (9 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.
- ❑ Separate signed and dated explanations for any "Yes" answers on Application; attach all pertinent documentation.
- ❑ Separate signed and dated explanations/descriptions of all malpractice claims made against you in the past ten years. For claims older than 10 years please provide a signed and dated explanation/description for settlements or judgments in excess of $500,000.
- ❑ Completed Authorization and Release
- ❑ Completed Arkansas Medical Practices Act and Rules Affidavit
- ❑ Completed Secondary Contact Designation form, if applicable
- ❑ CBC Privacy Right Statement
- ❑ Current Curriculum Vitae (CV)
- ❑ Copy of Driver's License or Passport *
- ❑ 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.)* *
- ❑ Copy of DD Form 214 (Certificate of Release or Discharge from Active Duty), if you have been released or discharged from any branch of the U.S. Armed Forces at any time during or since Medical School.

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

(forms marked with an asterisk (*) are not required if you are utilizing the FCVS for ACGME training programs – ** NOTE ** FCVS will not provide verification of non-ACGME training programs, which includes observerships, externships and foreign postgraduate training. Verification of non-ACGME training programs will require that you request the source to have documentation sent directly to this Board.

- ❑ **Examination Scores/Transcripts: ***
  NBME: Go to https://apps.nbme.org/nlesweb/#/login to request a score document online.
  USMLE, **FLEX**, **SPEX**: Go to https://usmle.fsmb.org/ to request an "Examination and Board Action History Report".
  COMLEX-USA OR COMVEX: Go to http://www.nbome.org/ to request the score document online.

- ❑ **Status Report of ECFMG Certification** - *(Foreign Medical Graduates only)* *
  Go to https://cvsonline2.ecfmg.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. ASMB will accept official transcripts from third party sources such as Parchment and National Student Clearinghouse.

- ❑ **Verification of Clinical Clerkship** (form included in packet) - *(Foreign Medical Graduates only)* *
  Send a copy of this form to the appropriate official(s) that can verify completion of your clinical clerkship(s). This form is not required if the clerkships are included on the medical school transcript.

- ❑ **Verification of Postgraduate Training** (form included in packet) *
  Send a copy of this form to the Program Director of every postgraduate training program you participated in.

- ❑ **Verification of Licensure** - **The ASMB will obtain these**. (form included in packet to be used only in the event you are asked to seek the verification) The ASMB must have verification of all licenses ever held, even temporary licenses and training permits, whether active or inactive.

- ❑ **Verification of Hospital/Surgical Center Affiliation** (form included in packet)
  Send to the Medical Staff Office or Administration Office of every hospital that granted you medical staff privileges. This does not include the hospitals where you completed postgraduate training *unless* they also granted you privileges to work outside the program (moonlighting, etc.). 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 - 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 Faculty (Teaching) Appointment** (form included in packet)
  Send to the Human Resources Department or Department Chairperson of every entity where you held a faculty appointment. 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.

- ❑ **Verification of Professional Liability Insurance** (form included in packet)
  Send to every malpractice insurance company that currently insures you against malpractice claims or a copy of your malpractice insurance certificate may be provided with your application.

- ❑ **Verification of Specialty Board Certification** (form included in packet) *
  The ASMB will verify certifications by member boards of the American Board of Medical Specialties. Send the verification request to every NON-ABMS specialty board that has ever certified you in any specialty.

- ❑ **Verification of Military Service** (form included in packet)
  If you are active duty or in the Reserves, complete the top portion of the form and then send with a copy of the Authorization & Release form (also in this packet) to your current duty station. If you are inactive military, you only need to provide a copy of your DD Form 214. ASMB will attempt to verify any current/prior active duty service via the Service-members Civil Relief Act (SCRA) website.

- ❑ **Malpractice Claims Documents**
  If, in the ten (10) years prior to the signature date of your application, you had a malpractice lawsuit filed against you OR if a malpractice settlement or judgment of $500,000 or more has ever been issued against you, you must submit a separate, signed and dated explanation of the circumstances for each lawsuit. Court documents are only required to be submitted for pending malpractice cases. If the case is settled, the NPDB report will suffice. If the claim is dismissed with no settlement, the applicant must have the insurance company provide a claims history report. For pending cases, the attorney must provide a narrative of the case as well as a copy of the Complaint. However, the applicant is still required to submit a signed and dated narrative for each case which meets the criteria set forth above.

- ❑ **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

NOTE: FCVS will not provide verification of non-ACGME training programs, which includes observerships, externships and foreign postgraduate training. Verification of non-ACGME training programs will require that you request the source to have documentation sent directly to this Board.

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

*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.

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 documents only.)
3. Provide exact dates (mm/dd/yyyy) whenever possible.
4. ANSWER ALL QUESTIONS/SECTIONS/INCLUDE ALL PAGES, even if your answer is "n/a," "Not Applicable," "None," or "Pending."
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 Parts IV and V 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 physician'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 License

- *Check Medicine/Surgery (MD) if you are a Medical Doctor, Osteopathic Medicine/Surgery (DO) if you are a Doctor of Osteopathy.*
- *Check Academic License if you are an international medical graduate who is seeking to practice medicine ONLY as authorized by A.C.A. § 17-95-412, and who does not meet the eligibility requirements for full licensure.*
- *If you are requesting a temporary license be issued prior to full licensure, check "Yes" and remit an additional $3 (three) with your application fees. You may choose to request a temporary license at a later date by sending a written request and the $3 (three) fee.*

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.
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 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, the Online Directory and the free, online license verification system. It is also available to the general public under 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 and other 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. 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:

a. If you plan to relocate to Arkansas, check "Yes" and enter the approximate date in the space provided. If you do not plan to relocate, check "No" and enter "n/a" in the space provided.
b. Enter the name and address of the hospital, clinic, group or private practice where you intend to practice. If you are a locum tenens or telemedicine physician, enter "Locum Tenens only" or "Telemedicine only" in this space.
c. If you are a telemedicine physician, check "Yes" and provide the name and telephone number of the telemedicine contract firm. If you are not a telemedicine physician, check "No." The Arkansas State Medical Board defines a telemedicine physician as one "who is physically located outside this state but who, through the use of any medium, including an electronic medium, performs an act that is part of a patient care service initiated in this state, including the performance or interpretation of an X-ray examination or the preparation of pathological material that would affect the diagnosis or treatment of the patient."

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

Questions 7 and 8:

a. Enter the full name of the medical school(s) 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."

If you are utilizing the Federation of State Medical Board's FCVS, request a profile be released to this office; otherwise, 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.

If you attended more than two medical schools, additional sheets may be attached.

Question 9:

Use this section to report, in chronological order, all medical and non-medical postgraduate education, including medical training, foreign postgraduate training, master's degrees and other doctorate degrees.

a. Enter the full name of the training program or graduate school.
b. For ACGME programs, enter the program ID. If not known, enter "Unknown."
c. Enter the type of program. (Internship, Residency, Fellowship, Observership, Ph.D., Masters, etc.)
d. Enter the specialty/subspecialty or the field of study.
e. Enter the name of the department.
f. Enter the mailing address of the program or graduate school.
g. Enter the date you started the program.
h. Enter the date you left the program.
i. If the program is still in process, enter the anticipated completion date in this space.
j. Check "Yes" if you completed the program, "No" if you did not. Check "In Process" if you are currently in the program. *If you did not complete the program, or if you completed the program in more or less time than the usual program length, you must submit a separate, signed and dated explanation of the circumstances.*

k. Check Yes/No box if chief resident.

If you participated in more than four programs, additional sheets may be attached.

If you are utilizing the Federation of State Medical Board's FCVS, request a profile be released to this office; otherwise, complete the top portion of the "Verification of Postgraduate Training" form and send it with any necessary fees to the Program Director or Registrar for completion. Forms must be returned directly to this office.

Question 10:

a. Enter the name of the Exam Series (and Step, if applicable). If you have indicated you have taken a state board exam, enter the state (state board exams taken after 1975 are not acceptable for licensure in Arkansas).
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.

If you are utilizing the Federation of State Medical Board's FCVS, request a profile be released to this office; otherwise, perform the following for exam information to be provided to this office.

For USMLE and/or FLEX and SPEX, visit the Federation of State Medical Examiners website (https://usmle.fsmb.org/ to request your USMLE and/or FLEX transcript be sent directly to this office.

For NBME, visit the National Board of Medical Examiners website (https://apps.nbme.org/nlesweb/#/login) to request your NBME transcript be sent directly to this office.

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

e. Check "Yes" if you have ever taken the SPEX or COMVEX examination, "No" if you have not. *If you have ever taken the SPEX or COMVEX exam, you must submit a separate, signed and dated explanation of the circumstances.*

Question 11:

a. If you are an International Medical Graduate, check "Yes" if you hold an ECFMG certification; "No" if you do not. If you are not an International Medical Graduate, check "N/A." *If you completed a Fifth Pathway program in lieu of the ECFMG, you must report the Fifth Pathway program in the Postgraduate Education section on page two of the application.* If you are not an International Medical Graduate, check "N/A." *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.

If you are utilizing the Federation of State Medical Board's FCVS, request a profile be released to this office; otherwise, visit the ECFMG website (https://cvsonline2.ecfmg.org) to request a Status Report of ECFMG Certification be sent directly to this office.

Questions 12, 13, and 14:

a. Enter your primary, secondary and tertiary practice specialty.
b. Check "Yes" if you are board certified in this specialty, "No" if you are not. If you are certified by a board that is not a member board of the American Board of Medical Specialties (ABMS), check "Yes."
c. Check "Lifetime" if this is a lifetime certification, "Time-Limited" if your certification will expire, "MOC" if you are currently meeting Maintenance of Certification requirements. Contact your specialty board for more information on Maintenance of Certification.
d. If you are board certified, enter the name of the certifying board, even if that board is not a member board of the ABMS. If you are not board certified, enter "n/a."
e. If you are board certified, enter the date of certification. If you are not board certified, enter "n/a."
f. If you are board certified, enter the date of your most recent recertification. If you are not board certified, or if you have not recertified or recertification is not required, enter "n/a."
g. If you are board certified, enter the date your certification will expire. If you are not board certified, or if your certification does not expire, enter "n/a."

Do not request this verification unless instructed to do so. Duplication of verifications can cause delays. *Your Licensing Coordinator may be able to obtain your board certification verification. However, you may be notified to request any that cannot be obtained. For that reason, a "Verification of Specialty Board Certification" form is*

included in the licensure packet. Complete the top portion of the "Verification of Specialty Board Certification" form and send it with any necessary fees to the specialty board for completion. Forms must be returned directly to this office from the specialty board.
If you have more than three specialties, additional sheets may be attached.

PART III - PROFESSIONAL ACTIVITIES

Question 15:

a. Enter each state or country in which you have been licensed. If you are not licensed in any other state, enter "n/a" and leave all other spaces blank.
b. Enter the license number. In some foreign countries, there is no formal licensure process (the issuance of a medical school diploma grants the physician the right to practice medicine). If this is the case for you, enter "n/a" in this space.
c. Enter the date on which the license was issued.
d. Enter the date on which the license expired or will expire. If the license does not expire, enter "n/a" in this space.
e. Enter your current status (Active, Inactive, Suspended, Revoked, etc.) *If any jurisdiction has ever suspended, limited, revoked or taken any other action against your license, you must submit a signed and dated explanation of the circumstances.*

Do not request this verification unless instructed to do so. Duplication of verifications can cause delays. *Your Licensing Coordinator may be able to obtain all of your US license verifications for you. However, you may be notified to request any that cannot be obtained. For that reason, a "Verification of Licensure" form is included in the licensure packet. Complete the top portion of the "Verification of Licensure" form and send it with any necessary fees to each Licensing Board for completion. Verifications must be returned directly to this office from the Licensing Board.*
If you have more than nine licenses, additional sheets may be attached.

Question 16:

a. Check "Yes" if you have ever served in the armed forces of the United States or any other country, "No" if you have not.
b. Enter the country and branch of service in which you served. If you have never served in the military, enter "n/a" and skip to #17.
c. Enter the date you entered the military.
d. Enter the date on which you were discharged from the military. If you are still in the military, enter "Current."
e. Enter the type of discharge (Honorable, General, etc.). If you are still in the military, enter "n/a."

If you have been discharged from the U.S. Military, you must provide a copy of your "DD Form 214." If you do not have your DD Form 214, visit the National Personnel Records Center website (http://www.archives.gov/veterans/military-service-records/get-service-records.html) to request Military Service Records be sent directly to this office.
If you are currently in the U.S. Military, you must have your current Commanding Officer submit a verification letter directly to this office ***OR*** *complete Parts I and II of the "Verification of Current Military Service" form and send it to the appropriate department in the United States military for them to complete and return to this office. Verifications must be returned from the source to this office.*
If you served in the military of a foreign country, provide the dates of service. Submit all documentation you have in support of your service to this office.

Question 17:

Include ALL professional activities, institutional affiliations or places of employment since graduation from medical school. This includes clinics, hospitals, teaching institutions, HMOs, private practice, employment, corporations, military assignments, government agencies, contract, moonlighting, locum tenens and telemedicine assignments. Also list leaves of absence since the beginning of medical school. Exclude residencies and fellowships previously listed as education. DO NOT ENTER "SEE CV;" THIS SECTION MUST BE COMPLETED EVEN THOUGH YOU ARE SENDING YOUR CURRICULUM VITAE. If you have no employment since medical school, please enter "N/A."

a. Enter the start date of the activity.
b. Enter the end date of the activity. If current, enter "Current."
c. Enter the type of affiliation. (Employment, Private Practice, Staff Appointment, Faculty Appointment, Personal Leave of Absence, etc.)
d. Enter the full name of the facility/institution. (Indicate if Primary practice or Previous practice)
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/staff category. (Partner, Owner, Staff Physician, Courtesy Staff, Locum Tenens, etc.)
g. Enter the specialty you practiced or in which you were granted privileges.

If you have more than eleven affiliations, etc., additional sheets may be attached.
For hospitals and surgery centers, complete the top portion of the "Verification of Hospital or Surgery Center Affiliation" form and send it with any necessary fees to each facility where you held privileges, even if moonlighting or providing locum tenens or telemedicine services.
For clinics, HMOs, employers or contract firms, 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.
For faculty appointments, complete the top portion of the "Verification of Faculty Appointment" form and send it with any necessary fees to each institution where you held faculty privileges. This does NOT include teaching duties during Residency or Fellowship.
If you have work history with a Locum Tenens, Contract, and/or Telemedicine Company, you will need to request a list of your assignments be submitted to this office directly from the contract, locum tenens, or telemedicine company along with a letter verifying your employment and good standing. This will need to include the name and address of each assignment facility, specialty, the start and end date (mm/dd/yyyy) and your position. This should be done in lieu of individual verification requests from each work assignment.

Question 18:

a. Enter the registration or certificate/license number. *If you do not have a Federal DEA, please enter "Choose not to carry," "Applied," "Pending," etc.*
b. For Federal DEA, enter "Fed." For State-issued controlled substance registrations, enter the two-letter postal code for the state.
c. Enter the address associated with this registration.
d. Enter the expiration date of this registration.

If you have more than six DEA or state-issued controlled substance registrations, additional sheets may be attached.
If the Federal DEA or any state agency has ever suspended, limited, revoked or taken any other action against your registration to prescribe scheduled drugs, you must submit a signed and dated explanation of the circumstances.

Question 19:
All time gaps of 30 days or more from the start of medical school must be explained.

a. Many applicants have a multi-week time gap between medical school and post graduate education. If you have a time gap of 30 days or more, please check "yes." If you do not have a time gap of 30 days or more between medical school and post graduate education, please check "no."
b. Provide dates of the time gap.
c. You must also provide an explanation for the time gap (e.g. traveling, moving, relocating, prepared for residency).
d-e. Provide dates and explanations for any additional time gaps of 30 or more days from the start of medical school.

If you have more than three total time gaps, additional sheets may be attached.
Please be advised that failure to address any time gaps of 30 days or more may result in delay of licensure.

Question 20:

a. Enter the date of the claim.
b. Enter the jurisdiction of the claim. (for example, "Lee County, MS")
c. Enter the disposition of the claim. (Dismissed Without Prejudice, Settled, Pending, etc.)
d. Amount of settlement or amount awarded to plaintiff.

List ALL CLAIMS you have ever had, regardless of how long ago. Court documents are only required for pending malpractice cases. If the case is settled and was reported to the NPDB, the NPDB report will suffice. If the claim is dismissed with no settlement, the applicant must have the insurance company provide a claims history report for all claims within the past ten (10) years. If the claim is pending, the applicant must have the attorney send a narrative of the case along with a copy of the Complaint. Regardless of outcome or status, the applicant is required to submit a signed and dated narrative of all cases filed.
If you have had more than five malpractice claims, additional sheets may be attached.
If you have no malpractice claims, please enter "N/A."

PART IV - ATTESTATION QUESTIONS

Question 21:
If "No," list the reason you are not covered by malpractice insurance. (not working, covered by Federal Tort Claims Act, etc.).
If "Yes," enter the insurance carrier name, policy number, expiration date, coverage amounts and the group name, if applicable.
If you are covered under more than one malpractice insurance policy, additional sheets may be attached.
Complete the top portion of the "Verification of Professional Liability Insurance" form and send it with any necessary fees to all CURRENT insurers, or include a copy of your current malpractice insurance certificate.

QUESTIONS 22-44:
For each "Yes" response to questions 22 through 44, 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.

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.

FOR QUESTION 28, ***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 41, *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 V - AFFIDAVIT OF APPLICANT

Read the affidavit completely before signing. Attach a passport-style photo, taken within the past sixty (60) days, in the space shown. 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 seal should be affixed below the photograph. The Notary's date must match your signature date. Applications received without a photo or the required Notary seal will be returned to the applicant for completion, thereby delaying the application process.

Arkansas State Medical Board
1401 West Capitol, Suite 340
Little Rock, AR 72201
Phone: (501) 296-1802
Fax: (501) 296-1972
www.armedicalboard.org

Arkansas State Medical Board – Fee Waiver Form

17-5-104. Fee waiver. [Effective January 1, 2022.]

(a) Notwithstanding any law to the contrary, a licensing entity shall not require an initial fee for individuals who are seeking to receive a license in this state if the applicant:

(1) Is receiving assistance through the Arkansas Medicaid Program, the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, the Temporary Assistance for Needy Families Program, or the Lifeline Assistance Program;

(2) Was approved for unemployment within the last twelve (12) months; or

(3) Has an income that does not exceed two hundred percent (200%) of the federal poverty income guidelines.

(b) The waiver of the initial fee does not include fees for:

(1) A criminal background check;

(2) An examination or a test; or

(3) A medical or drug test.

In accordance with Ark. Code Ann. § 17-5-104, the Arkansas State Medical Board will waive the initial application fee providing the following conditions are met:

Fee Waiver Eligibility
Check all that apply:

- ☐ Arkansas Medicaid Program
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC)
- ☐ Temporary Assistance for Needy Families Program (TANF)
- ☐ Lifeline Assistance Program
- ☐ Have been approved for unemployment within the last twelve (12) months
- ☐ Have an income that does not exceed two hundred percent (200%) of the federal poverty income guidelines

Proof of eligibility* for the fee waiver and this signed form must accompany the application at the time of submission.

_____ _____

Applicant Signature Applicant Printed Name

*Documentation must include:

- Official documentation from the agency providing the benefits that you are receiving that includes your approval for benefit assistance
- Copy of your most recent tax return to show proof of having income that does not exceed 200% of the federal poverty income guidelines

ARKANSAS STATE MEDICAL BOARD

1401 West Capitol, Suite 340 • Little Rock, AR 72201 • (501) 296-1802
www.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 MEDICAL LICENSURE 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 LICENSE YOU ARE APPLYING FOR (check one)

☐ Medicine/Surgery (MD) ☐ Osteopathic Medicine/Surgery (DO) ☐ Academic License

Are you requesting that a temporary license be issued prior to full licensure? ☐ Yes ☐ Not at this time

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 ☐ Male ☐ 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 ☐ Non-Hispanic ☐ Hispanic	3f. Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Hawaiian/Pacific Islander ☐ Hispanic

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	5a. If not currently living in Arkansas, do you plan to relocate? ☐ No ☐ Yes - Approx. date: _____

5b. Intended Practice Location in Arkansas: Name and Address of Hospital, Clinic, Group or Private Practice

5c. Will you be providing telemedicine services from outside the state of Arkansas?
☐ No ☐ Yes - Name of Telemedicine Contract Firm: _____ Phone _____

6a. NPI Number	6b. Accept Medicaid/Medicare Patients? ☐ Medicare ☐ Medicaid ☐ Neither ☐ 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. If you completed medical school in more or less than four years, provide the reason 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? ☐ Yes ☐ No	7g. Degree Awarded ☐ M.D. (or foreign equivalent) ☐ D.O. ☐ None
8a. Institution Name			8b. Country of Medical School
8c. Mailing Address (Street Address, City, State/Country, Zip Code)			
8d. Start Date / /	8e. End Date / /	8f. Graduated? ☐ Yes ☐ No	8g. Degree Awarded ☐ M.D. (or foreign equivalent) ☐ D.O. ☐ None

POSTGRADUATE EDUCATION, US OR FOREIGN

List internships, residencies, fellowships and other postgraduate training chronologically (attach additional sheets if necessary). If you did not complete a program or changed schools between years, provide the reason on a separate sheet of paper, signed and dated by you. If program still in process, enter anticipated completion date as end date.

9a. Full Name of Training Program				9b. Program ID (if known)
9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty		9e. Department Name	
9f. Mailing Address (Street Address, City, State/Country, Zip Code)				
9g. Start Date / /	9h. End Date / /	9i. Anticipated End Date / /	9j. Completed? ☐ Yes ☐ No ☐ In Process	9k. Chief resident? ☐ Yes ☐ No
9a. Full Name of Training Program				9b. Program ID (if known)
9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty		9e. Department Name	
9f. Mailing Address (Street Address, City, State/Country, Zip Code)				
9g. Start Date / /	9h. End Date / /	9i. Anticipated End Date / /	9j. Completed? ☐ Yes ☐ No ☐ In Process	9k. Chief resident? ☐ Yes ☐ No
9a. Full Name of Training Program				9b. Program ID (if known)
9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty		9e. Department Name	
9f. Mailing Address (Street Address, City, State/Country, Zip Code)				
9g. Start Date / /	9h. End Date / /	9i. Anticipated End Date / /	9j. Completed? ☐ Yes ☐ No ☐ In Process	9k. Chief resident? ☐ Yes ☐ No
9a. Full Name of Training Program				9b. Program ID (if known)
9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty		9e. Department Name	
9f. Mailing Address (Street Address, City, State/Country, Zip Code)				
9g. Start Date / /	9h. End Date / /	9i. Anticipated End Date / /	9j. Completed? ☐ Yes ☐ No ☐ In Process	9k. Chief resident? ☐ Yes ☐ No

EXAMINATION HISTORY	Please specify exam series USMLE, NBME, FLEX, NBOME, COMLEX, LMCC (or State Exam prior to 1975). *If you failed any step of any examination, even once, you must submit a separate, signed and dated explanation of the circumstances.* Attach additional sheets if necessary.		
10a. Exam Series & Step	10b. Number of Attempts	10c. Number of times failed	10d. Date PASSED / /
10a. Exam Series & Step	10b. Number of Attempts	10c. Number of times failed	10d. Date PASSED / /
10a. Exam Series & Step	10b. Number of Attempts	10c. Number of times failed	10d. Date PASSED / /
10a. Exam Series & Step	10b. Number of Attempts	10c. Number of times failed	10d. Date PASSED / /

10e. Have you ever taken the SPEX or COMVEX examination? ☐ Yes ☐ No If Yes, you must provide a signed and dated explanation.

11a. If you are an International medical graduate, do you hold an ECFMG certification? ☐ Yes ☐ No ☐ N/A (If No, you must provide a signed and dated explanation)	11b. ECFMG Certificate No.	11c. Date Issued / /

SPECIALTY/ BOARD CERTIFICATION	Please list all specialties, including self-designated. Attach additional sheets if necessary.		
12a. Primary Practice Specialty/Subspecialty	12b. Board Certified? ☐ Yes ☐ No	12c. Certification Type ☐ Lifetime ☐ Time-Limited ☐ MOC	
12d. Name of Specialty Board, if certified	12e. Certification Date / /	12f. Recertification Date / /	12g. Expiration Date / /
13a. Secondary Specialty/Subspecialty	13b. Board Certified? ☐ Yes ☐ No	13c. Certification Type ☐ Lifetime ☐ Time-Limited ☐ MOC	
13d. Name of Specialty Board, if certified	13e. Certification Date / /	13f. Recertification Date / /	13g. Expiration Date / /
14a. Tertiary Specialty/Subspecialty	14b. Board Certified? ☐ Yes ☐ No	14c. Certification Type ☐ Lifetime ☐ Time-Limited ☐ MOC	
14d. Name of Specialty Board, if certified	14e. Certification Date / /	14f. Recertification Date / /	14g. Expiration Date / /

PART III - PROFESSIONAL ACTIVITIES

PROFESSIONAL LICENSURE	List all states or territories of the United States or other countries in which you **hold** or **have ever held** a medical license. Include all temporary, instructional and training permits/licenses. Attach additional sheets if necessary. If none, enter "N/A."			
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date / /	15d. Expiration Date / /	15e. Current Status
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date / /	15d. Expiration Date / /	15e. Current Status
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15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date / /	15d. Expiration Date / /	15e. Current Status

MILITARY SERVICE	Submit a copy of your separation papers (DD Form 214) with your application. If Active Duty, have the Verification of Current Military Service sent to this office or have your current Commanding Officer submit a verification letter directly to this office.

16a. Have you ever been in the armed forces? ☐ Yes ☐ No

16b. Country & Branch of Service	16c. Date of Entry / /	16d. Date of Discharge / /	16e. Type of Discharge
16b. Country & Branch of Service	16c. Date of Entry / /	16d. Date of Discharge / /	16e. Type of Discharge

WORK HISTORY	Please provide a chronological listing for all medical and non-medical work history and other activities, including hospitals, faculty appointments, private practice, employment corporations, military assignments, government agencies, locum tenens and telemedicine assignments, and leaves of absence since graduation from 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."**

17a. Date From / /	17b. Date To / /	17c. Type of Affiliation, (Primary or Previous Practice, Employment, Staff Appointment, etc.)

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice

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17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

WORK HISTORY, continued

17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
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17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in

FEDERAL DEA & STATE-ISSUED CONTROLLED SUBSTANCE REGISTRATIONS	List all current and previous Federal DEA and state-issued controlled substance registrations. If none, enter N/A.		
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /

TIME GAPS	Please provide an explanation for ALL time gaps of 30 days or more since the start of medical school. If none, enter N/A.
19a. Did you have a time gap in excess of 30 days between medical school and post-graduate training? ☐ Yes ☐ No	19b. Dates of time gap
19c. Explanation for time gap: (e.g. traveling, vacation, moving, prepared for residency)	
19d. Additional time gap. Provide dates and explanation.	
19e. Additional time gap. Provide dates and explanation. Use additional sheets if necessary.	

MALPRACTICE CLAIMS	List **all** malpractice claims ever filed against you, regardless of disposition. If none, enter "n/a". Use additional sheets if necessary.		
20a. Date of Claim / /	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid $
20a. Date of Claim / /	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid $
20a. Date of Claim / /	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid $
20a. Date of Claim / /	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid $
20a. Date of Claim / /	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid $
20a. Date of Claim / /	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid $
20a. Date of Claim / /	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid $
20a. Date of Claim / /	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid $
20a. Date of Claim / /	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid $
20a. Date of Claim / /	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid $

PART IV - ATTESTATION QUESTIONS

21. Do you currently maintain individual or group Professional Liability Insurance (malpractice) coverage? ☐ No ☐ Yes
If no, list reason: _____.
Insurance Carrier Name: _____
Policy Number(s): _____
Expiration Date: _____ Coverage Amounts: _____
If Group policy, list group name: _____

SPECIAL INSTRUCTIONS FOR QUESTIONS 22-44

- **Please mark the appropriate box next to each question. Do not leave any questions blank.**
- **For each "Yes" response to questions 22-44, 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.

22. Has your application for examination or licensure ever been rejected, denied or withdrawn? *If yes, explain.* ☐ No ☐ Yes

23. Has any medical licensing board ever placed your license on probation, suspension, or has it revoked a license or certificate it had granted you? *If yes, explain and provide name and address of Board.* ☐ No ☐ Yes

24. Have you ever been ordered to appear before a state medical board for any reason other than licensure? *If yes, explain.* ☐ No ☐ Yes

25. Has a medical board or hospital ever initiated disciplinary procedures against you? *If yes, explain*. ☐ No ☐ Yes

26. Have your privileges at any hospital ever been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? *If yes, explain.* ☐ No ☐ Yes

27. Have you ever voluntarily surrendered your medical license in any state? *If yes, explain.* ☐ No ☐ Yes

28. 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

29. Have you ever been denied provider participation in any state or federal Medicaid program? *If yes, explain.* ☐ No ☐ Yes

30. Have you ever been warned, censured by, or requested to withdraw from any hospital in which you have been trained, been a staff member, or held hospital privileges? *If yes, explain.* ☐ No ☐ Yes

31. Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during an internship, residency, or fellowship program? *If yes, explain*. ☐ No ☐ Yes

32. Have you ever voluntarily or involuntarily left a training institution program before completing it? *If yes, explain.* ☐ No ☐ Yes

PART IV - ATTESTATION QUESTIONS, continued

33. Have you ever been reported to the National Practitioner Data Bank or subject to NPDB adverse action reporting? *If yes, explain.* ☐ No ☐ Yes

34. Have you ever resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted? *If yes, explain.* ☐ No ☐ Yes

35. Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending? *If yes, explain.* ☐ No ☐ Yes

36. Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicare/Medicaid program? *If yes, explain.* ☐ No ☐ Yes

37. Have you ever been cited by a peer review organization? *If yes, explain.* ☐ No ☐ Yes

38. Have you ever had to discontinue practice for any reason for a period longer than one (1) month? *If yes, explain.* ☐ No ☐ Yes

39. 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

39a. If Yes, was this the result of a medical board action? ☐ No ☐ Yes

40. 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

41. Are you currently being, or have you ever been monitored by a Physicians Health Committee in any state? *If yes, explain, and ask the Physician Health Committee to send documentation of your status.* ☐ No ☐ Yes

42. Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? *If yes, explain.* ☐ No ☐ Yes

43. Have you ever defaulted on any Health Education Assistance loan? *If yes, explain.* ☐ No ☐ Yes

44. To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? *If yes, explain.* **If, during the application process, you become aware of any such investigation, you are required to report it to this office.** ☐ No ☐ Yes

PART V - 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 below the photograph at left)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE 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 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AFFIDAVIT

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE ANNOTATED SECTION 17-95-101, et. seq., AND THE RULES 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

& CENTRALIZED CREDENTIALS VERIFICATION SERVICE
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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

1401 West Capitol, Suite 340 ● Little Rock, AR 72201 ● (501) 296-1802 ● Fax (501) 296-1972
www.armedicalboard.org ● Support@armedicalboard.org
Email attachments must be in PDF format

THIS NOTIFICATION SHOULD BE DETACHED AND RETAINED BY APPLICANT

FINGERPRINTS SUBMITTED WITH THIS APPLICATION WILL BE USED TO CHECK FBI CRIMINAL RECORDS

NOTIFICATIONS FORM

To obtain a Copy of your FBI Criminal Record:
Procedures for obtaining a copy of FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.30 through 16.33 or go to the FBI website at http://www.fbi.gov/about-us/cjis/background-checks

Changes, Corrections, or Updating of Federal Criminal Record:
Procedures for obtaining a change, correction, or updating of an FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34 or go to the FBI website at http://www.fbi.gov/about-us/cjis/background-checks

If, after viewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wish changes, corrections, or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Service (CJIS) Division, and ATTN: SCU, Mod. D2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting the agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency

Appeal of Determination:
If your determination is based on an error such as wrong person, birth date, etc., please contact Health Facility Services Criminal History determination section at 501-661-2201. You may appeal a determination error within sixty (60) days by submitting a written request to: Health Facility Services Criminal History Appeals, 5800 W. 10th Street, #400, Little Rock AR 72204. Include your contact information and a description of the error.

Arkansas Code §A.C.A. 20-38-101

PRIVACY RIGHT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

APPLICANT TO REVIEW AND SIGN

- I HEREBY GIVE MY CONSENT FOR THE ARKANSAS STATE POLICE AND THE FBI TO CONDUCT THE REQUIRED CRIMINAL RECORD CHECK ON MYSELF AND RELEASE ANY RESULTS TO THE LICENSING AUTHORITY AND THE STATE RESULTS TO THE QUALIFIED ENTITY
- I RECEIVED WRITTEN DIRECTIONS FOR CHANGES/CORRECTING/UPDATING MY FBI CRIMINAL RECORD
- I RECEIVED WRITTEN DIRECTIONS ON HOW TO OBTAIN A COPY OF MY FBI CRIMINAL RECORD
- I RECEIVED WRITTEN DIRECTIONS ALONG WITH THE TIME FRAME EXPLAINING HOW TO APPEAL THE ACCURACY/DISPOSITION INFORMATION

STATEMENT OF OATH:

I STATE ON OATH THAT THE REPRESENTATIONS MADE HEREIN ARE TRUE AND CORRECT.

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

Printed name of applicant *Signature of applicant* *Date*

ARKANSAS STATE MEDICAL BOARD

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

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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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) / /
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.		
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 ❒ M.D. (or foreign equivalent) ❒ D.O. ❒ 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? *[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.]*		❒ 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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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 CLINICAL CLERKSHIP (International Medical Graduates Only)

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, Country, Postal 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) / /
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.		
Physician Signature		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY CLINICAL CLERKSHIP 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 Institution (if not correct above)		
Department or Specialty	Date Clerkship Began / /	Date Clerkship Ended / /
If the physician did not complete his/her clerkship, please provide explanation (use additional sheets if necessary).		
If clerkship was in more or less than the usual program length, please provide explanation (use additional sheets if necessary).		
During this physician's clinical clerkship, was he/she ever investigated or disciplined by the school or program for any reason? *[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.]*	❒ 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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DATE OF REQUEST: .....

VERIFICATION OF POSTGRADUATE TRAINING

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

PGE Program Name: .....
Dept. or Program Director: .....
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 Completion (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.		
Physician Signature		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY PROGRAM DIRECTOR OR 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 Postgraduate Training Program	Chief Resident? ☐ Yes ☐ No Date _____

Type of Program
❒ Internship ❒ Residency ❒ Clinical Fellowship ❒ Research Fellowship ❒ Assistantship ❒ Clerkship ❒ Externship
❒ Observership ❒ Other (please specify):_____

Date Training Began / /	Date Training Ended or Anticipated Completion Date / /	Program Specialty or Subspecialty

If program was completed in more or less than the customary program length, please provide explanation (use additional sheets if necessary).

Was program completed successfully? *[If No, please explain (use additional sheets if necessary)]* ❒ In Process ❒ Yes ❒ No

During the program, was this physician ever investigated or disciplined for any reason? ❒ Yes ❒ No
[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 copies of the training records/evaluations and summary letter from the Program Director.]

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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DATE OF REQUEST: .....

VERIFICATION OF SPECIALTY BOARD CERTIFICATION

PART I – SPECIALTY BOARD NAME AND MAILING ADDRESS - PART I AND PART II TO BE FILLED OUT BY APPLICANT - REQUIRED FOR VERIFICATION TO BE ACCEPTED

Specialty Board Name: .....

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) / /
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.		
Physician Signature		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY SPECIALTY BOARD 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 Specialty Board (if not correct above)		
Is this Specialty Board a member of the American Board of Medical Specialties (ABMS)? ❒ Yes ❒ No		
Specialty in which physician is/was certified (if more than one, please provide a separate verification for each)	Certificate Number	
Certification Type ❒ Lifetime ❒ Time-Limited ❒ Other _____		
Participating in MOC ❒ Yes ❒ No		
Certification Status ❒ Certified ❒ Recertified ❒ Expired/Lapsed ❒ Other _____		
Original Certification Date / /	Last Recertification Date / /	Expiration Date / /

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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DATE OF REQUEST: .....

VERIFICATION OF LICENSURE

PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – LICENSING AUTHORITY NAME AND MAILING ADDRESS

Name of Licensing Authority: .....

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) / /
Other Names Used		License Number for this state or country

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.

Physician Signature	Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY LICENSING AUTHORITY 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.

State/Country	Name of Licensing Authority (if not correct above)	
License Number	Original Issue Date (mm/dd/yyyy) / /	Expiration Date (mm/dd/yyyy) / /

Current License Status
❒ Active ❒ Inactive ❒ Temporary ❒ Other:_____

License Category
❒ Unlimited ❒ Educational ❒ Other:_____

Please answer the following questions and attach explanations and dates for any "Yes" answers.

Has this physician ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction, or is any such investigation pending?	❒ Yes	❒ No
Have formal disciplinary proceedings been initiated against this physician or the physician's license by a licensing or disciplinary authority in your state or jurisdiction, or is any such action pending?	❒ Yes	❒ No
Has this physician's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state, or is any such action pending?	❒ 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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DATE OF REQUEST: .....

VERIFICATION OF PROFESSIONAL LIABILITY INSURANCE –

PART I AND PART II TO BE FILLED OUT BY APPLICANT-
REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – INSURANCE CARRIER AND AGENCY NAME AND MAILING ADDRESS

Name of Insurance Carrier: .....

Name of Insurance Agency: .....

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) / /
Policy Number	If Group Policy, name of Group	
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Physician Signature		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY INSURANCE CARRIER OR AGENCY 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 Insurance Carrier	Name of Agency/Producer		
Agency/Producer Address (if not correct in address block above)			
Policy Number	Date Coverage Began / /	Date Coverage Ends / /	Retroactive Date / /
Coverage Type ❒ Occurrence-based ❒ Claims-based ❒ Tail Coverage	Coverage Limits $ _____ / $ _____		

Have any specific procedures been excluded from this coverage? If yes, please list procedures.	❒ Yes	❒ No
Has your insurance company defended this provider in any professional liability suits?	❒ Yes	❒ No
Does your insurance company currently have any pending judgments or settlements on behalf of this provider?	❒ Yes	❒ No
Has your insurance company paid judgments or settlements on behalf of this provider?	❒ Yes	❒ No

If you answered "Yes" to any of the above questions, please provide both a claims history report AND a full explanation of the details on a separate sheet, including the name of the court in which the suit was filed, the caption and docket number of the case, and the name and address of the attorney who defended this physician.

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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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) / /
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.		
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 ❒ Current ❒ Inactive ❒ Leave of Absence ❒ Other _____		
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.
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). ❒ Yes ❒ No ❒ 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

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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) / /
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.		
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 ❒ Current ❒ Inactive ❒ Leave of Absence ❒ Other _____		
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.
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). ❒ Yes ❒ No ❒ 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

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DATE OF REQUEST: .....

VERIFICATION OF HOSPITAL OR SURGERY CENTER AFFILIATION

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

PART I – FACILITY NAME AND MAILING ADDRESS

Name of Facility: .....

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) / /
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.		
Physician Signature		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY FACILITY 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 Facility (if not correct above)		
Current Staff Status ❒ Current ❒ Inactive ❒ Leave of Absence	Current or Most Recent Staff Category ❒ Active ❒ Consulting ❒ Courtesy ❒ Temporary ❒ _____	
Specialties and/or Subspecialties in which clinical privileges were last held		Department
Date Privileges Began (including temp or provisional) / /	Date Privileges Ended / /	❒ If exact dates are not available, please check here. If currently appointed, please write "Present" in the space for end date.

Note: Breaks in appointment should be listed as separate entries. If the physician 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 appointment dates.

Did this physician act as a TELEMEDICINE physician for your facility? *[Did the physician, while physically located outside your region and through the use of an electronic or other medium, perform acts that are part of a patient care service initiated at your facility?]*	❒ Yes	❒ No
To the best of your knowledge, are/were the physician's clinical privileges in good standing during the stated period of time? *(if No, please attach detailed explanation)*	❒ Yes	❒ No
Were the clinical privileges of this physician ever denied, revoked, limited or suspended? *(if Yes, please attach detailed explanation)*	❒ 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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DATE OF REQUEST: .....

VERIFICATION OF FACULTY APPOINTMENT

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

PART I – INSTITUTION NAME AND MAILING ADDRESS

Name of Institution: .....

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) / /
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.		
Physician Signature		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY INSTITUTION 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 Institution (if not correct above)		
Current Staff Status ❒ Current ❒ Inactive ❒ Leave of Absence ❒ Other _____		
Date Appointed to Faculty / /	Date Appointment Ended / /	❒ If exact dates are not available, please check here. If currently appointed, please write "Present" in the space for end date.
Note: If there are breaks between appointments, each time period should be listed separately, either by copying this form for each time period, or by attaching a separate sheet detailing appointment dates.		
Current or Most Recent Faculty Position/Title		
Department(s)	Specialties and/or Subspecialties	
To the best of your knowledge, during the stated period of time, was this faculty member in good standing? ❒ Yes ❒ No *(if No, please attach detailed explanation)*		

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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DATE OF REQUEST: .....

VERIFICATION OF CURRENT MILITARY SERVICE

PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – MILITARY NAME AND MAILING ADDRESS

Name of Duty Station: .....

Name of Current Commanding Officer: .....

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 AUTHORIZED PERSONNEL ONLY)

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

Branch of Service		
Present Status ❒ Current ❒ Inactive ❒ Leave of Absence ❒ Other _____		
Date Service Began / /	Date Service Ended / /	❒ If exact dates are not available, please check here. If currently in the military, write "Present" in the space for end date.
Current or Most Recent Position/Title		
To your knowledge, during the stated period of time, was the applicant in good standing? If No, please explain (attach additional sheets if needed). ❒ Yes ❒ No ❒ 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

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Inactive U.S. military personnel should provide proof of service by submitting a copy of his/her DD Form 214 with their application in lieu of completing this form.