



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

OCCUPATIONAL THERAPY LICENSURE INFORMATION PACKET

This packet contains all of the documents you will need to apply for an Occupational Therapy or Occupational Therapy Assistant license 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from a source other than directly from the Arkansas State Medical Board or its official website, the application may be outdated or not an official version. Please be advised that outdated or unofficial versions of the application will not be accepted.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. Abandoned files will be maintained for 30 days and then destroyed. No refunds will be given on abandoned/inactive applications over twelve (12) months old.

APPEARING BEFORE THE BOARD. For your application to be placed on the Board Meeting agenda, it must be complete and all required documentation, including staff investigations, must be in this office. THERE ARE NO EXCEPTIONS TO THIS POLICY. Applicants who have disciplinary actions and/or impairment history may be required to make a personal appearance before the Board. 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.

APPLICATION FEES. The fee for an Occupational Therapy license is **\$75**. The fee for an Occupational Therapy Assistant license is **\$50**. There is an additional **\$25** fee if you are requesting that a temporary permit be issued prior to full licensure. Fees must be included with your application at the time of submission. Payment may be made by check or money order payable to *ASMB*.

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

ARKANSAS MEDICAL PRACTICES ACTS AND REGULATIONS. The Arkansas Occupational Therapy Act (Arkansas Code §17-88-101, et seq.) must be read in its entirety prior to submitting an application for an Occupational Therapy or Occupational Therapy Assistant license to the Arkansas State Medical Board. You **MUST** complete the Rules & Regulations Affidavit included in this packet. Applications received without this form will be returned. The Arkansas Occupational Therapy Act is part of the Arkansas Medical Practices Acts and Regulations, which can be viewed and downloaded from our web site, www.armedicalboard.org.

CHANGE OF ADDRESS. Regulation 33 requires you to notify the Arkansas State Medical Board of any changes to your address within 30 days of such change. This includes your relocation to Arkansas, if applicable. A change of address form is available for download at our website, www.armedicalboard.org. Any 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 which allows communication between the Board and the applicant 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 e-mails from various interested parties checking on the status of your application. It also allows you to review the progress of your application at any time. You may wish to provide access to your application data to anyone whom you choose; 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. This step cannot be skipped.

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

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

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

Arkansas Code §17-95-306 states:

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

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

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

LICENSE RENEWAL. Your Occupational Therapy or Occupational Therapy Assistant 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 e-mail 60 days prior to the end of your birth month. A follow up e-mail will be sent at approximately 45 days and a final e-mail 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 \$25.00 late fee to reinstate your license and you will be required to submit copies of your certificates of completion for continuing education units. *******REMINDER** ***** **It is illegal to practice occupational therapy 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 several weeks to complete. Please plan for this. Do not make commitments, purchase a home, or relocate your family before your Arkansas Occupational Therapy license has been granted. Applications are processed in the order in which they are received in our office and in the order verification documents are provided. The board does NOT accelerate one applicant over another.

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

SUPERVISING OCCUPATIONAL THERAPIST. By law, Occupational Therapy Assistants are allowed to practice only under the supervision of a licensed Occupational Therapist. It is the responsibility of the OTA to keep this office informed of your current Supervising OT in Arkansas.

TEMPORARY PERMITS. You may request that a temporary permit be granted only if you meet the educational requirements and have **NOT** passed the NBCOT examination, so that you can begin working in Arkansas before the Board considers your request for a permanent license. 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 on the application and the required fee of \$25 must accompany your request. Temporary permits expire 30 days after the NBCOT eligibility date, and can be extended ONE time by submitting a written request and an additional \$25 fee. Issuance of a temporary permit does NOT guarantee that a permanent license will be granted. Completed files are submitted to the Board each Thursday for consideration of a temporary permit, and all temporary permits granted can be verified online (<http://www.armedicalboard.org/public/verify/default.aspx>) on the following Friday after 2:00pm.

TIME GAPS. Any time gaps of 30 days or more 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 we have experienced in receiving mail that has been sent to us, we strongly recommend you utilize FedEx, UPS, or other *guaranteed* delivery service when sending your application or other documents to us. We further recommend 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 us in a timely manner.

VERIFICATIONS. It is the policy of this board that ALL education and professional affiliations and other activities since graduation from Occupational Therapy School (or within the past 5 years whichever is less) 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. Applicants are required to sign verification documents where indicated in Part II prior to sending to the verification source. The verifier's signature can be original, stamped or computer-generated. All verifications can be faxed or e-mailed unless specifically requested to be mailed. To fax, send to (501) 296-1972, Attn: Licensing - OT. To e-

mail, the document must be attached as an Adobe PDF file and sent 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.

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

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

OCCUPATIONAL THERAPY REQUIREMENTS FOR LICENSURE IN ARKANSAS

OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS MUST MEET THE FOLLOWING CONDITIONS:

- (1) Must be at least 18 years of age.
- (2) Must be of good moral character.
- (3) Must have successfully completed the academic requirements of an educational program in Occupational Therapy with concentration in biologic or physical science, psychology and sociology, and with education in selected manual skills:
 - (A) For an Occupational Therapist, the program shall be accredited by the American Medical Association in collaboration with the American Occupational Therapy Association and shall lead to the awarding of a bachelor's or master's level degree or advanced standing certification in occupational therapy.
 - (B) For an Occupational Therapy Assistant, the program shall be approved by the American Occupational Therapy Association and shall lead to the awarding of an associate level degree in occupational therapy.
- (4) Must have successfully completed a period of supervised field work experience at a recognized educational institution where he or she met the following academic requirements:
 - (A) For an occupational therapist, a minimum of six (6) months supervised field work experience is required.
 - (B) For an Occupational Therapy Assistant, a minimum of two (2) months of supervised field work experience at an approved facility other than the one at which the person was previously employed, if applicable, is required.
- (5) Must have passed an examination approved by the Board.
- (6) Must complete a background check.
- (7) Must present indisputable identification.
- (8) Must submit a completed application with a licensure fee of \$75 for Occupational Therapist and \$50 for Occupational Therapy Assistant.

LICENSURE IS BY CREDENTIALS:

- Credentials must be verified from the originating source; verifications received from applicants will not be accepted.

LICENSING EXAMINATION MEETING THE BOARD REQUIREMENTS IS AS FOLLOWS:

- NBCOT

LICENSE APPLICATION CHECKLIST

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

USE THE FOLLOWING ADDRESS FOR ALL DOCUMENT SUBMISSION:

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

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

- Check or money order, made payable to *ASMB*, in the amount of \$75 for Occupational Therapy, \$50 for Occupational Therapy Assistant. Add \$25 if also requesting a temporary permit on either license.
- Application (5 pages), signed, with passport-style photo (attached to page 5) and certification by Notary Public. Signature must be original and must be made in black or dark blue ink. Stamped signatures, signatures by proxy and signatures by Power of Attorney are NOT accepted. Do not complete the application on front and back pages. Use one sided pages only.
- Signed and dated explanations for any "Yes" answers in Part IV of the Application. Attach all pertinent documentation.
- Signed and dated explanations for any time gaps of 30 days or more since graduation from occupational therapy school.
- Completed Occupational Therapy Authorization and Release (form in packet).
- Completed Arkansas Medical Practices Acts and Rules and Regulations Affidavit (form in packet).
- Copy of Driver's License or Passport.
- Copy of name change documents, if applicable.
- Copy of proof of citizenship, naturalization, or visa, 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 served in any branch of the U.S. Armed Forces at any time since occupational therapy school.
- Copy of current résumé.

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:

- NBCOT Certification Verification** (if you have taken and passed the examination)
Go to www.nbcot.org to request a verification of certification be sent directly to this office.
- NBCOT Score Report** (if you have not yet taken and passed the examination)
Go to www.nbcot.org to apply for the exam and to request an "Official Score Transfer" to the State of Arkansas. There is a fee for this service. Please Note: ASMB will not receive a report unless you select this option and pay for this service. Failing to order this service from NBCOT will delay your file for licensure.
- Verification of Occupational Therapy Education AND Official Transcript** (form in packet)
Complete Parts I and II of this form, and send to the Dean or Registrar of occupational therapy school/program you attended. The completed form and transcript must be sent directly from the source to this office.

- Verification of Licensure** (form in packet)
Board staff will obtain these for you online. However, in the event a state does not offer the license verification online, if there is a fee, or the website has not been updated, the applicant will be responsible for requesting and paying any fees. The ASMB must have verification of all licenses ever held, even temporary licenses, whether active or inactive.

- Verification of Hospital/Facility Affiliation** (form in packet)
Complete Parts I and II of this form, and then send a copy to the Department Director or Administration Office of every facility that has granted you Occupational Therapy privileges or has employed you as an OT or OTA in the last five (5) years or since graduation from Occupational Therapy school, whichever is shorter. The completed form or an equivalent verification letter must be sent directly from the source to this office.

- Verification of Military Service**
If you are still in the armed forces, request that your current Commanding Officer submit a verification letter directly to this office. If you are former military, you only need to provide a copy of your DD Form 214 if you have served since graduating occupational therapy school.

- Verification of Employment (Non-Therapy)** (form in packet)
Complete Parts I and II of this form, and then send a copy to every employer where you have worked in a non-therapy-related position within the last five (5) years, or since graduation from occupational therapy school, whichever is shorter. The completed form or an equivalent verification letter must be sent directly from the source to this office.

- 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. 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

INSTRUCTIONS FOR COMPLETING LICENSURE APPLICATION

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, 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 Part IV of the application, you must attach a signed and dated explanation.
7. Failure to answer all questions completely and accurately, or the omission or falsification of information, may be cause for denial of your application or disciplinary action if you are subsequently granted a license. WHEN IN DOUBT, DISCLOSE AND EXPLAIN ALL INFORMATION.
8. All signatures must be the applicant's; stamped signatures, signatures by proxy, and signatures by power of attorney are NOT accepted.

Type of License:

Check either Occupational Therapy or Occupational Therapy Assistant.

If you wish to obtain a temporary permit prior to full licensure, please note: You are eligible for a temporary permit **only** if you have **not** yet taken or passed the NBCOT examination. If you fail the examination the first time, you will only be eligible to receive one more temporary permit to give you the opportunity to take the examination a second time.

Question 1: Your Name

- a. Enter your legal name as listed on your driver's license. If your name has changed due to marriage, divorce, adoption or naturalization, submit a notarized copy of the pertinent documentation.
- b. Enter any other names used during your education or career, such as maiden name, nicknames, etc.

Question 2: Your Identification

- a. Enter your social security number.
- b. Enter your driver's license number and state abbreviation. *Send a copy of your driver's license with your license application.*
- c. Check male or female.
- d. Enter your date of birth (mm/dd/yyyy).

Question 3: Birthplace/Citizenship

- 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.
- 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: Your Contact Information (Both address sections must be completed, even if they are the same.)

- a. Enter your Public mailing address. **This field is required.** This address appears on all printed reports, bulk data listings, the Online Directory and the free, online license verification system. It is also available to the general public under Freedom of Information (FOI), and all other reports available to the credentialing organizations utilizing the ASMB website for license and/or credentials verification.
- b. Enter your Private mailing address. **This field is required.** The Private address is used to send renewal reminders, direct and confidential communication from the Board and the Board's quarterly Newsletter. It is NOT available to the public under FOI unless you also use this address as your public address.
- c-f. Enter your private, work, fax, and mobile phone numbers in the appropriate spaces.
- g. Enter your personal e-mail address. **Your personal e-mail address is required.** This is the e-mail address through which you will receive automated system messages as to the status of your application. You may also receive private and confidential e-mails for clarification purposes from the licensing staff. This is NOT your primary contact's e-mail address, as this e-mail address will carry over towards the required online renewal setup.

Question 5: Intended Practice Location

- a. Enter the name of the hospital, clinic, group or private practice where you will be practicing in Arkansas. If you do not know your intended practice location, enter "Unknown."
- b. Enter the mailing address of the hospital, clinic, group or private practice where you will be practicing. If you do not know your intended practice location, enter "Unknown."

Question 6: Education

- a. Enter the full name of the occupational therapy school/program where you completed your Occupational Therapy or Occupational Therapy Assistant undergraduate and graduate (if applicable) education. *Complete Parts I and II of the "Verification of Occupational Therapy Education" form contained in the application packet and send one to the school. This form should only be completed and submitted after graduation; any forms submitted before graduation are invalid and must be submitted again. Forms must be returned directly to this office from the institution.*
- b. Enter the mailing address of the school/program.
- c. Enter the date you started attending the school/program.
- d. Enter the date you graduated the school/program.
- e. Answer "Yes" if you graduated, "No" if you did not graduate.
- f. Enter the degree you were awarded.

Question 7: Examination

Answer "Yes" if you passed the NBCOT examination, "No" if you did not.

- a. Enter the name of the exam.
- 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 have taken and passed the exam, have certification verification from NBCOT mailed directly to this office. If you have not taken and passed the exam, have NBCOT send an Eligibility to Examine Notice directly to this office. Your full license cannot be presented for determination until all documents and verifications are received and your application file is determined to be complete.*

Question 8: Licenses

- a. If you have never held an OT or OTA license (including temporary or training permit) in another state or country, enter "None" in the first space and proceed to Question 10. If you have held an OT or OTA license in another state or country, enter the name of that state or country here. Additional sheets may be attached, if necessary.
- b. Enter your OT or OTA license number.
- c. Enter the date the OT/OTA license was originally issued.
- d. Enter the date the OT/OTA license expired or will expire.
- e. Enter "Yes" if this license is still active, "No" if it is not. *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.

Question 9: Military Service

- a. Answer "Yes" if you have ever served in the armed forces of the U.S. or any other country since graduating from Occupational Therapy School. Answer "No" if you have not. *If Active Duty or Active Reserves, 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.*
- b. Enter the country and branch you served.
- c. Enter the date you entered the armed forces.
- d. Enter the date you were discharged from the military.
- e. Enter the type of discharge you received (Honorable, General, etc.)

Question 10: Work History

- a. Additional sheets may be attached, if necessary. You must list all professional activities since graduation from occupational therapy school. Do NOT enter "See résumé." If you ever took a leave of absence of 30 days or more from an employer, or if there was a gap of 30 days or more between the end of one activity and the beginning of the next, you must provide a separate, signed and dated explanation for the time gap. *Complete Parts I and II of the "Verification of Hospital/Facility Affiliation" and send one to the appropriate department at each hospital, clinic, group or private practice where you worked as an OT or OTA within the past five (5) years or since graduating from occupational therapy school, whichever is shorter. Complete Parts I and II of the "Verification of Employment (Non-Therapy)" and send one to the appropriate department at each place you have worked that is non-therapy-related within the last five (5) years, or since graduating from occupational therapy school, whichever is shorter. Verifications must be returned directly from the source to this office.*
- b. Enter the mailing address of the employer. *If the facility is closed, enter the last known address and indicate the facility is closed.*
- c. Enter the date your employment began.
- d. Enter the date your employment ended.
- e. Enter your title or position with this employer.
- f. Enter your current status with this employer (Active or Inactive).

QUESTIONS 11-18 (ATTESTATION QUESTIONS):

For each "YES" response to questions 11 through 18, 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. If, during the application process, you become aware of any investigation, action, or other circumstance relating to questions asked in this section, you are required to report it to this office.

FOR QUESTIONS 11 and 12:

If you answer "yes" to either of these questions, in addition to the written explanation outlined above, you must also attach a copy of the charging document, judgment or conviction, indicate whether paroled or placed on probation, and how probation was completed for any arrest/charge in the past 10 years.

If you have or had a record that was sealed, expunged or pardoned, you are still required to answer "Yes" to this question.

Affidavit of Applicant (Signature Page):

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

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

APPLICATION FOR OCCUPATIONAL THERAPY LICENSURE IN ARKANSAS

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 question before answering; remember, you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in Part IV of the application, you MUST submit a separate 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.

TYPE OF LICENSE FOR WHICH YOU ARE APPLYING (check one)

Occupational Therapy

Occupational Therapy Assistant

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 (City and State/Country)

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 Hispanic

Black/African American White Hawaiian/Pacific Islander

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

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

4c. Private Phone #

4d. Work Phone #

4e. Fax #

4f. Mobile Phone #

4g. Personal E-mail Address

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

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

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Application Received:

/ /

Fee Received: \$

1st Temp Permit #:

1st Temp Issued:

/ /

1st Temp Expires:

/ /

2nd Temp Permit #:

2nd Temp Issued:

/ /

2nd Temp Expires:

/ /

OT/OTA License #:

Full License Issued:

/ /

PART II - EDUCATION

UNDERGRADUATE AND GRADUATE EDUCATION

List all occupational therapy schools/programs you attended (attach additional sheets if necessary). Have each school complete and submit the Verification of Education form and official transcript directly to this office.

6a. Full Name of Institution and Program

6b. Mailing Address (Street Address, City, State, Zip Code)

6c. Start Date

/ /

6d. End Date

/ /

6e. Graduated?

Yes No

6f. Degree Awarded, or reason why you did not graduate

6a. Full Name of Institution and Program

6b. Mailing Address (Street Address, City, State, Zip Code)

6c. Start Date

/ /

6d. End Date

/ /

6e. Graduated?

Yes No

6f. Degree Awarded, or reason why you did not graduate

EXAMINATION HISTORY

7. Have you passed the NBCOT Exam? Yes No

If Yes, have NBCOT send the Verification of Certification to this office.
If No, have NBCOT send the Eligibility to Examine Notice to this office and request an Official Score Transfer.

7a. Exam

7b. Number of Attempts

7c. Number of times failed

7d. Date PASSED

/ /

7a. Exam

7b. Number of Attempts

7c. Number of times failed

7d. Date PASSED

/ /

7a. Exam

7b. Number of Attempts

7c. Number of times failed

7d. Date PASSED

/ /

7a. Exam

7b. Number of Attempts

7c. Number of times failed

7d. Date PASSED

/ /

PART III - PROFESSIONAL

PROFESSIONAL LICENSURE

List all states or territories of the United States, provinces of Canada, or other countries in which you hold or have ever held an Occupational Therapy license, including all temporary, instructional, and training permits/licenses. Attach additional sheets if necessary.

8a. Jurisdiction (State, Country)

8b. License No.

8c. Issue Date

/ /

8d. Expiration Date

/ /

8e. Active? (Yes/No)

8a. Jurisdiction (State, Country)

8b. License No.

8c. Issue Date

/ /

8d. Expiration Date

/ /

8e. Active? (Yes/No)

8a. Jurisdiction (State, Country)

8b. License No.

8c. Issue Date

/ /

8d. Expiration Date

/ /

8e. Active? (Yes/No)

8a. Jurisdiction (State, Country)

8b. License No.

8c. Issue Date

/ /

8d. Expiration Date

/ /

8e. Active? (Yes/No)

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.

9a. Have you ever been in the armed forces since graduating from occupational therapy school? Yes No

If yes, complete questions 9b-9e.

9b. Country & Branch of Service

9c. Date of Entry

/ /

9d. Date of Discharge

/ /

9e. Type of Discharge

WORK HISTORY

Please provide a chronological listing of all therapy and non-therapy work history and other activities, including hospitals, private practice, employment, time gaps and leaves of absence since graduation from Occupational Therapy school. **You must provide explanations of any time gaps and leaves of absence of 30 days or more since graduation from Occupational Therapy School. Do not write, "See résumé." If none, enter "N/A."**

10a. Name of Institution/Facility/Employer

10b. Mailing Address (Street or PO Box, City, State, Zip Code)

10c. Date From

/ /

10d. Date To

/ /

10e. Title/Position

10f. Status

10a. Name of Institution/Facility/Employer

10b. Mailing Address (Street or PO Box, City, State, Zip Code)

10c. Date From

/ /

10d. Date To

/ /

10e. Title/Position

10f. Status

10a. Name of Institution/Facility/Employer

10b. Mailing Address (Street or PO Box, City, State, Zip Code)

10c. Date From

/ /

10d. Date To

/ /

10e. Title/Position

10f. Status

10a. Name of Institution/Facility/Employer

10b. Mailing Address (Street or PO Box, City, State, Zip Code)

10c. Date From

/ /

10d. Date To

/ /

10e. Title/Position

10f. Status

10a. Name of Institution/Facility/Employer

10b. Mailing Address (Street or PO Box, City, State, Zip Code)

10c. Date From

/ /

10d. Date To

/ /

10e. Title/Position

10f. Status

PART IV - ATTESTATION QUESTIONS

SPECIAL INSTRUCTIONS FOR QUESTIONS 11-18

- Please mark the appropriate box next to each question. Do not leave any questions blank.
- For each “Yes” response to questions 11-18, 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 all information and provide an explanation.**
- Failure to answer these questions accurately may result in disciplinary action or denial of license.
- Confidentiality: The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a “Yes” answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.

11. Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony? (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
12. Have you ever been cited for, arrested for, charged with, or convicted of a DWI (Driving while Intoxicated) or DUI (Driving Under the Influence)? How many? _____ *If yes, explain.* No Yes
13. Do you have any physical, mental or emotional impairment that has the potential to hinder your ability to perform duties assigned in any healthcare profession including that of Occupational Therapy? *If yes, explain.* No Yes
14. Have you ever been addicted to alcohol or drugs? *If yes, explain.* No Yes
15. Have you ever been treated for alcohol/substance abuse in a treatment center or hospital? *If yes, give name of institution, date and length of stay in your explanation.* No Yes
16. Has any medical or occupational therapy licensing board or NBCOT ever sanctioned you or your certification? *If yes, list name and address of board/entity in your explanation.* No Yes
17. Have you ever voluntarily surrendered your OT license in any other jurisdiction, state or territory? *If yes, give name and address of board in your explanation.* No Yes
18. Have you ever previously made application to the Arkansas State Medical Board? *If yes, explain.* No Yes

continue to next page

DO NOT WRITE EXPLANATIONS IN THIS SPACE.

Temporary Permit Signature - To be completed for Temporary Permit Applicants only

Signature of an Occupational Therapist who is currently fully licensed to practice in Arkansas, with whom the applicant will practice in association as stipulated in Regulation No. 6, Section 3.2 of the Arkansas Occupational Therapy Act.

Name of Fully Licensed Arkansas OT

Signature of Fully Licensed Arkansas OT

OTR

Arkansas License #

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 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 as an Occupational Therapist or Occupational Therapy Assistant in the State of Arkansas.

AFFIX
PASSPORT-STYLE
PHOTOGRAPH
HERE

Applicant's Signature (in ink)

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

Date Signed

(must include the month, day and year signed)

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

_____ day of _____, 20 _____.

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

My commission expires: _____

Notary Signature

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



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

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

Occupational Therapy / Occupational Therapy Assistant

I AFFIRM THAT I HAVE READ THE OCCUPATIONAL THERAPY ACT, ARKANSAS CODE ANNOTATED §17-88-101, *et seq.*, AND THE RULES AND REGULATIONS (REGULATION 6) OF THE ARKANSAS STATE MEDICAL BOARD.

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

Practitioner's Signature (no rubber stamps)

Signature Date

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

**YOU MUST COMPLETE THIS FORM AND RETURN IT TO:
ARKANSAS STATE MEDICAL BOARD
1401 WEST CAPITOL AVE., SUITE 340
LITTLE ROCK, AR 72201**



ARKANSAS STATE MEDICAL BOARD

OCCUPATIONAL THERAPY LICENSURE DEPARTMENT

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

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

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

ARKANSAS MEDICAL PRACTICES ACTS & REGULATIONS FOR OCCUPATIONAL THERAPISTS AND ASSISTANTS

To practice lawfully, you must know the legal requirements pertaining to your profession. The following questions represent a sample of the law and regulations governing the practice of Occupational Therapy in the State of Arkansas, §17-88-101 through §17-88-312 and Regulation No. 6.

It is your professional responsibility to know the legal requirements surrounding the practice of your profession and be alert to changes in those requirements. This questionnaire is intended to provide you with a measure of your working knowledge of those requirements. You will find the answers within the OT Practice Act available online at our website, www.armedicalboard.org. This questionnaire is an extension of the Rules and Regulations Affidavit, also enclosed. **Both documents must be returned with your application.** Questions will be modified at the discretion of the Occupational Therapy Examining Committee.

Name of OT or OTA: _____ **Date:** _____

Write the letter of the correct answer.

1. _____ **The OTs shall assign, and the OTA shall accept, only those duties and responsibilities for which the OTA has been specifically trained and is qualified to perform, pursuant to the judgment of the OT.**
 - a) True
 - b) False

2. _____ **The Supervising Occupational Therapist shall meet with the Occupational Therapy Assistant for on-site, face to face supervision a minimum of _____ performed by Occupational Therapy Assistant to review each patient's progress and objectives.**
 - a) Every two (2) weeks
 - b) One (1) hour per forty (40) occupational therapy work hours
 - c) Once a month

3. _____ **Each Occupational Therapist and Occupational Therapy Assistant must complete 12 hours of continuing education a year.**
 - a) True
 - b) False

4. _____ **When the Board requests proof of CEU courses submitted for renewal and/or audit purposes, which one of the following are acceptable documentation to maintain and provide?**
 - a) Receipt for payment of training
 - b) A handwritten list of classes completed with dates
 - c) A letter from supervisor stating that 10 hours of CEU have been completed
 - d) A brochure
 - e) Official transcripts documenting completion of Occupation Therapy related coursework

5. _____ **An applicant can re-take failed exams as many times as needed to pass without restriction.**
 - a) True
 - b) False

6. _____ **Each Occupational Therapy Assistant will maintain for a period of three (3) years proof of a supervision log, should it be requested by the Board for audit purposes.**
a) True
b) False
7. _____ **A temporary license will only be renewed one (1) time if the applicant has not passed the examination or if the applicant has failed to take the qualifying examination, unless that failure is justified by good cause acceptable at the discretion of the secretary.**
a) True
b) False
8. _____ **The Occupational Therapy Assistant may not evaluate independently or initiate treatment prior to the Occupational Therapist's evaluation.**
a) True
b) False
9. _____ **An Occupational Therapist licensed in another state must take an exam to be issued a license to practice in Arkansas.**
a) True
b) False
10. _____ **License renewals are due:**
a) Yearly based on the date your license was granted
b) Yearly, before or on the last day of your birth month
c) Every two years based on the date your license was granted



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AUTHORIZATION AND RELEASE

To Whom It May Concern:

This document will authorize and direct any healthcare practitioners 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 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 Practitioner: _____

Social Security Number: _____

Signature of Practitioner: _____

Dark Blue or Black Ink Only - No Signature Stamps

Signature Date: _____



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SECONDARY CONTACT DESIGNATION FORM

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

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

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

Print full name of Secondary Contact

Organization Name

E-mail address of Secondary Contact

Phone number of Secondary Contact

Print full name of Applicant

Signature of Applicant (no signature stamps)

Date Signed

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



ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

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

DATE OF REQUEST: _____

VERIFICATION OF OCCUPATIONAL THERAPY EDUCATION

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

PART I – INSTITUTION NAME AND MAILING ADDRESS

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

PART II – APPLICANT INFORMATION

| | | |
|--|--|--|
| Full Name (Last, First, Middle) | Social Security Number XXX-XX- ____ - ____ - ____ | Date of Birth (mm/dd/yyyy) / / |
| Other Names Used | | Date of Graduation (mm/dd/yyyy) / / |
| <i>AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.</i> | | |
| Applicant Signature (no electronic or stamped signature) | | Date Signed (mm/dd/yyyy) / / |

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

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

| | | |
|---|----------------------------------|--|
| Name of Occupational Therapy School (if not correct above) | | |
| Date O.T. Education Began / / | Date O.T. Education Ended / / | Degree Awarded (ex: Master of Occupational Therapy) <input type="checkbox"/> None |
| If program was not completed, or was completed in more or less than the customary time frame for such training, please provide explanation (use additional sheets if necessary). | | |
| During this applicant's education, was he/she ever investigated or disciplined by the school for any reason? <i>[Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted or otherwise disciplined. If you respond "Yes" to this question, please provide a detailed explanation on a separate sheet, signed and dated by the person whose signature appears below.]</i> | | <input type="checkbox"/> Yes <input type="checkbox"/> 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 |

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



ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

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

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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 – APPLICANT 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 | |
| <i>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.</i> | | |
| Applicant Signature (no electronic or stamped 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 applicant 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 <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Temporary <input type="checkbox"/> Other: _____ | | |
| License Category <input type="checkbox"/> Unlimited <input type="checkbox"/> Educational <input type="checkbox"/> Other: _____ | | |
| Please answer the following questions and attach explanations and dates for any "Yes" answers. | | |
| Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction, or is any such investigation pending? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction, or is any such action pending? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has this applicant'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? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 |

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



ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

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

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

DATE OF REQUEST: _____

VERIFICATION OF HOSPITAL/FACILITY AFFILIATION

PART I AND PART II TO BE FILLED OUT BY 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 – APPLICANT INFORMATION

| | | |
|--|--|-----------------------------------|
| Full Name (Last, First, Middle) | Social Security Number XXX-XX- ____ | Date of Birth (mm/dd/yyyy) / / |
| Other Names Used | | |
| <i>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.</i> | | |
| Applicant Signature (no electronic or stamped 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 applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

| | | |
|--|-------------------------------|---|
| Name of Facility (if not correct above) | | |
| Current Staff Status <input type="checkbox"/> Current <input type="checkbox"/> Inactive <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other _____ | | |
| Date Affiliation Began (including temp or provisional) / / | Date Affiliation Ended / / | <input type="checkbox"/> 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 applicant was there intermittently, a listing of each time period he/she was appointed to your facility's ancillary staff should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing appointment dates. | | |
| Current or most recent Position/Title | | |
| To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed). <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Unable to comment, Reason: | | |

PART IV - VERIFIED BY

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

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



ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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

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

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

DATE OF REQUEST:

VERIFICATION OF EMPLOYMENT (Non-Therapy)

(for verification of employment that did not involve occupational therapy)

PART I AND PART II TO BE FILLED OUT BY 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 – APPLICANT INFORMATION

| | | |
|--|---|-----------------------------------|
| Full Name (Last, First, Middle) | Social Security Number XXX-XX- ____ - ____ | Date of Birth (mm/dd/yyyy) / / |
| <i>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.</i> | | |
| Applicant Signature (no electronic or stamped 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 applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

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

PART IV - VERIFIED BY

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

**PLEASE RETURN THIS FORM DIRECTLY TO THE
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ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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Documents submitted by e-mail must be sent in PDF format to support@armedicalboard.org

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) / / |
| <i>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.</i> | | |
| 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 <input type="checkbox"/> Current <input type="checkbox"/> Inactive <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other _____ | | |
| Date Service Began / / | Date Service Ended / / | <input type="checkbox"/> 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). <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Unable to comment | | |

PART IV - VERIFIED BY

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

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

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.