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

- ☐ Are you adding a new supervising physician? or
- ☐ Replacing your supervising physician?

Name of former supervising physician _____ Date supervision ended (former supervising physician) _____

PHYSICIAN ASSISTANT SUPERVISING PHYSICIAN APPLICATION

1. This form is to be filled out by the prospective Supervising Physician.
2. Type or print legibly (in dark blue or black ink). (one sided only)
3. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.

IMPORTANT INFORMATION

THE FOLLOWING ITEMS MUST BE INCLUDED WHEN SUBMITTING THIS APPLICATION:

1. **Payment in the amount of $50.00, to be paid by the Supervising Physician. Make check payable to ASMB.**
2. **Arkansas Medical Practices Act and Rules and Regulations Affidavit, signed by Supervising Physician.**
3. **Copy of Supervising Physician's Federal DEA registration certificate.**
4. **Copy of Supervising Physician's current professional liability insurance certificate.**
5. **Protocol signed and dated by PA, Supervising Physician and Back-up Supervising Physician(s)**

Not sending these items together will result in a delay of the application process.

PHYSICIAN ASSISTANT

Physician Assistant's Full Name	License No. (if applicable)

SUPERVISING PHYSICIAN INFORMATION

Supervising Physician's Name	Medical License Number

Complete Practice or Office Address (PO Box or Street, City, State, Zip Code)

Office Telephone Number	Office Fax Number	Home Telephone Number	Cellular Telephone #

E-mail Address	Specialty	Board Certified?
		☐ Yes ☐ No

Type or Scope of Practice

Services Rendered

Area or Geographic Range of Practice

Type of Facility

☐ Private Practice ☐ Clinic ☐ Hospital ☐ Other _____

DO NOT WRITE IN THIS SPACE – FOR OFFICE USE ONLY

FEE RECEIVED $_____ FEE RECEIVED DATE: _____

BACK-UP SUPERVISING PHYSICIAN(S) INFORMATION (attach additional sheets if necessary)	
Back-up Supervising Physician #1	Medical License Number
Complete Practice or Office Address (PO Box or Street, City, State, Zip Code)	
When will Back-up Supervising Physician be utilized?	
Back-up Supervising Physician #2	Medical License Number
Complete Practice or Office Address (PO Box or Street, City, State, Zip Code)	
When will Back-up Supervising Physician be utilized?	

PHYSICIAN ASSISTANTS CURRENTLY UNDER YOUR SUPERVISION		
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? ☐ Supervising ☐ Back-up	P.A. AR License Number
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? ☐ Supervising ☐ Back-up	P.A. AR License Number
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? ☐ Supervising ☐ Back-up	P.A. AR License Number

Supervising Physician's Signature

Date Signed

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

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

(Supervising Physician)

I AFFIRM THAT I HAVE READ THE PHYSICIAN ASSISTANT ACT, ARKANSAS CODE 17-105-101, *et seq.*, AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD. I UNDERSTAND THAT I TAKE FULL RESPONSIBILITY FOR THE ACTIONS OF _____ WHILE HE/SHE IS UNDER MY SUPERVISION.

_____
Supervising Physician's Full Name (First Middle Last, Suffix, Degree)

_____
Supervising Physician's Signature (no rubber stamps)

_____
Signature Date

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