



# ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201-2936

Phone (501) 296-1802 Fax (501) 296-1972 [www.armedicalboard.org](http://www.armedicalboard.org)

Emails with attachments must be sent in PDF format to [support@armedicalboard.org](mailto:support@armedicalboard.org)

## PHYSICIAN ASSISTANT LICENSURE INFORMATION PACKET

This packet contains all of the documents you will need to apply for a license in Arkansas. This packet and each of its components are available on our web site, [www.armedicalboard.org](http://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from a source other than directly from the Arkansas State Medical Board or its official website, the application may be outdated or not an official version. Please be advised that outdated or unofficial versions of the application will not be accepted.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.

**APPLICATION FEES.** The fee for full licensure is \$90 (\$80 application fee plus \$10 for temporary license), and must be included with your application at the time of submission. Payment may be made by check or money order payable to ASMB - Arkansas State Medical Board.

**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 Medical Practices Acts and Regulations must be read in their entirety prior to submitting an application for a Physician Assistant license to the Arkansas State Medical Board. You **MUST** complete the Rules & Regulations Affidavit located in this packet. Applications received without this form will be returned. The Medical Practices Act can be viewed and downloaded from our web site, [www.armedicalboard.org](http://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](http://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 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. 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 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. This step cannot be skipped. Once all verifications have arrived and all time gaps filled, your application file will be presented for licensure consideration.

**COMMITTEE APPEARANCE.** All applicants and supervising physicians will be required to appear together before the Physician Assistant Advisory Committee prior to licensure, and may also have to appear when there is a change of supervising physicians. Licenses are granted ONLY at regularly scheduled meetings. Meeting dates may change at the discretion of the Committee or the Arkansas State Medical Board. Meeting dates are available on our website, [www.armedicalboard.org](http://www.armedicalboard.org). Appearance dates will be provided to you by your Licensing Coordinator.

**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 two 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 Physician 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 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 \$25.00 late fee to reinstate your license. \*\*\*\*\***REMINDER**\*\*\*\*\* **It is illegal to practice as a Physician's Assistant in this State with 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 Physician Assistant license has been granted. 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.

**PROTOCOL REQUIREMENT.** The protocol is a physician drafted document which describes how you and the physician will work together with practice guidelines required by the supervising physician. It must delineate the scope of practice that you will engage in and how you will be evaluated and supervised. You are strongly encouraged to use the "Example Protocol" as a template for creating your protocol, as the document contains parameters required by the PA Advisory Committee and the foundation for basic patient treatment by a PA. You may add or delete services and/or procedures as it applies to your working relationship. Each area listed on the "Example Protocol" must be included in your submitted protocol or it will be returned for completion.

Please refer back to the Medical Practices Act and Regulation 24 for specific details and the PA application packet for an example - <http://www.armedicalboard.org>.

**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.

**SUPERVISING PHYSICIAN.** By law, Physician Assistants are allowed to practice only under the supervision of a licensed physician. It is the responsibility of the PA to keep this office informed of your current Supervising Physician in Arkansas.

**TEMPORARY PERMITS.** A temporary permit may be granted to an applicant who meets all the qualifications for licensure but is awaiting the next scheduled meeting of the Physician Assistant Advisory Committee. Consideration of a temporary permit can be made only when the application process is completed in its entirety. The temporary permit will expire at the next scheduled meeting unless extended, and can be extended only once. The applicant must appear with his or her Supervising Physician for approval of the protocol within four (4) months of when the first temporary permit was granted.

**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 will 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 which 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, training, and professional affiliations and other activities since graduation from Physician Assistant 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. Applicants are required to sign verification documents where indicated in Part II prior to sending to 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. To e-mail, the document must be sent as an Adobe .pdf attachment to [support@armedicalboard.org](mailto: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 which 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.

## **PHYSICIAN ASSISTANT REQUIREMENTS FOR LICENSURE IN ARKANSAS**

### **ARKANSAS MEDICAL PRACTICES ACT, 17-105-102 (b) AND REGULATION 24: THE BOARD MAY GRANT A LICENSE AS A PHYSICIAN ASSISTANT TO AN APPLICANT WHO:**

- (1) Submits an application on forms approved by the board;
- (2) Pays the appropriate fees as determined by the board;
- (3) Has successfully completed an educational program for physician assistants or surgeon assistants accredited by the Committee on Allied Health Education and Accreditation or by its successor agency and has passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA).
- (4) Certifies that he or she is mentally and physically able to engage safely in practice as a Physician Assistant;
- (5) Has no licensure, certification, or registration as a Physician Assistant under current discipline, revocation, suspension, or probation for cause resulting from the applicant's practice as a Physician Assistant, unless the board considers such condition and agrees to licensure;
- (6) Is of good moral character;
- (7) Submits to the board any other information the board deems necessary to evaluate the applicant's qualifications;
- (8) Has been approved by the board;
- (9) Is at least twenty-one (21) years of age; and
- (10) After July 1, 1999, has at least a bachelor's degree in some field of study from a regionally accredited college or university, unless the applicant has:
  - (A) Prior service as a military corpsman and is a graduate of a Physician Assistant education program recognized by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs or the applicant is currently certified by the National Commission on Certification of Physician Assistants.
  - (B) Was serving as a Physician Assistant in a federal facility located in the State of Arkansas on or after July 1, 1999, and who is a graduate of a Physician Assistant education program recognized by the Committee on Allied Health Education Programs;
  - (C) Was licensed in good standing on July 30, 1999, by the Arkansas State Medical Board; or
  - (D) Was enrolled on or before July 1, 1999 in a Physician Assistant program recognized by the Commission on Accreditation of Allied Health Education Programs.

### **LICENSURE IS BY CREDENTIALS:**

- Credentials must be verified from the originating source; verifications received from applicants will be returned

### **LICENSING EXAMINATIONS MEETING THE BOARD REQUIREMENTS ARE AS FOLLOWS:**

- Physician Assistant National Certifying Examination (PANCE)

## 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 W CAPITOL AVE, SUITE 340  
LITTLE ROCK AR 72201-2936

### **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 \$90.00, for temporary and full licensure.
- Application, signed, with photo attached 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/descriptions of all malpractice claims made against you
- Signed and dated explanations for any time gaps of 30 days or more since the end of education
- Completed Physician Assistant Authorization and Release (form in packet)
- Completed Arkansas Medical Practices Acts and Rules and Regulations Affidavit (form in packet)
- Completed Secondary Contact Designation if desired (form in packet)
- Current Curriculum Vitae (CV) (Sign and date)
- Copy of Driver's License or Passport
- Copies of all previous and current Federal DEA registration certificates and state-issued controlled substance registration certificates
- 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 Physician Assistant 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:**

- Verification of Undergraduate Education and Official Transcript** (form in packet)  
Complete Parts I and II, sign and then send a copy to the Dean or Registrar of each college, university, or technical school you attended.
- Verification of Physician Assistant Education and Official Transcript** (form in packet)  
Complete Parts I and II, sign and then send a copy to the Dean or Registrar of each Physician Assistant school you attended.

- NCCPA PANCE Results/Eligibility**  
Go to <http://www.nccpa.net>. If you have taken and passed the exam, request the Exam Results be sent. If you have not taken the exam, request the Eligibility Letter be sent.
- Verification of Licensure** (form in packet)  
The applicant is no longer required to request verification of their out-of-state Physician Assistant licenses, except for those states that do not provide free, online verification through their website (MS and SD, for example). In these states, the applicant will be required to request verification and pay any required fees. If any verifying source charges a fee for verification, does not offer online verification, or if their website has not been updated, the applicant is responsible for requesting verification and paying any fees. Complete Parts I and II of the form, sign and then send a copy to the licensing board.
- Verification of Hospital/Clinic Physician Assistant Affiliation** (form in packet)  
Complete Parts I and II, sign and then send to the Medical Staff Office or Administration Office of every hospital and every clinic that granted you Physician Assistant privileges or employed you as a Physician Assistant.  
Locum Tenens: Verification from each assignment facility is no longer required, as long as the locum tenens contract firm can provide a list of all of the applicant's assignments with exact dates.
- Professional Liability Verification** (form in packet)  
The ASMB does NOT require applicants to have malpractice insurance prior to licensure. However, if you do carry malpractice insurance, send this form to every insurance company that currently insures you against malpractice claims. The completed form may be returned to ASMB by fax.
- 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 not required to be submitted for 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. However, the applicant is still required to submit a signed and dated narrative for each case which meets the criteria set forth above.
- Verification of Military Service** (form 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 Physician Assistant Authorization & Release form (also in this packet) to your current duty station or you can have your Commanding Officer send a letter to the Board. If you are inactive military, you only need to provide a copy of your DD Form 214. If you do not have a copy of your DD214, go to <http://www.archives.gov/veterans/military-service-records/> to request online.
- Supervising Physician Application** (form in packet)  
Send to your Supervising Physician for completion.
- Back-Up Supervising Physician Application** (form in packet)  
Send to your Back-up Supervising Physician for completion.
- Protocol** (example in packet)  
Create a protocol, sign and have Supervising Physician and Back-up Supervising Physician sign. (The applicant can provide this document to the Board.)
- Physician/Professional Reference/Recommendation Letter**  
Only one (1) signed and dated letter of recommendation is required. It cannot be from a physician who will be your supervising physician in Arkansas. To assure timely processing of your application, please communicate the following guidelines for submitting recommendation letters to the Board:
  - Letter must be written or typed on standard size paper or letterhead and must include the date, address, and phone number of the sender. The name of the sender must be legible.
  - Letter can be e-mailed to the Board from the reference's personal e-mail address.
  - Letter must include your full, legal name. If an alternate name, nickname or the English translation is used, your full, legal name must still be referenced somewhere in the letter.
  - Letter must indicate whether or not they have worked with the applicant and state the work experience with the applicant regarding his or her knowledge base.
  - Letter must indicate their observation of the applicant's integrity or character.



# INSTRUCTIONS FOR COMPLETING LICENSURE APPLICATION

## READ CAREFULLY!

### Question 1: Your name

- 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 pertinent document.
- Enter any other names used during your education or career, such as maiden name, nicknames, etc.

### Question 2: Your identification

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

### Question 3: Birthplace/Citizenship

- Enter the city and state (or city and country) where you were born.
- Enter the name of the country of which you are a citizen. *If you are a U.S. citizen but you were born in a foreign country, send a copy of your proof of citizenship.*
- If you are not a U.S. citizen, enter your immigration status. *Send a copy of your current Visa or Work Permit.* If you are a U.S. citizen, enter "n/a".
- If you are not a U.S. citizen, enter the number of years and/or months that you have lived in the U.S. If you are a U.S. citizen, enter "n/a".
- Indicate your ethnicity by checking the appropriate box.
- 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.)

- 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.
- 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.
- Enter your private, work, fax, and mobile phone numbers in the appropriate spaces.
- 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

- Enter the name of the hospital, clinic, group or private practice where you will be practicing.
- Enter the mailing address of the hospital, clinic, group or private practice where you will be practicing.
- Enter the name of the physician that will be your Supervising Physician. If you have not found employment at the time of application, enter "pending."
- Enter your Supervising Physician's specialty. Please note that, per Regulation 24(7)(D), *"The supervising physician and back-up supervising physician must be skilled and trained in the same scope of practice as the tasks that have been assigned to and will be performed by the Physician Assistant that they supervise."*
- Enter the name of the physician that will be your Back-up Supervising Physician.
- Enter your Back-up Supervising Physician's specialty.

### Question 6: Undergraduate Education

- Enter the full name of the college or university where you completed your undergraduate education. The application has space for two different schools in case you transferred. If you attended more than two schools, additional sheets may be attached.
- Enter the mailing address of the college or university.
- Enter the date you started attending the college or university.
- Enter the date you left the college or university (graduated or left before completion).
- Answer "Yes" if you graduated, "No" if you did not graduate.
- Enter the degree you were awarded, or list the reason why you did not graduate (transferred schools, extended leave of absence, etc.). *If you did not graduate, you must submit a separate, signed and dated explanation of the circumstances.*

*Complete the top portion of the "Verification of Undergraduate Education" form contained in the application packet, and send one to each college or university you attended. Forms must be returned directly to this office from the institution.*

### Question 7: Physician Assistant Education

- Enter the full name of the college or university program where you completed your Physician Assistant education. The application has space for two different programs in case you transferred. If you attended more than two programs, additional sheets may be attached.
- Enter the mailing address of the program.
- Enter the date you started attending the program.



- d. Enter the date you left the program (graduated or left before completion).
- e. Answer "Yes" if you graduated, "No" if you did not graduate.
- f. Enter the degree you were awarded, or list the reason why you did not graduate (transferred schools, extended leave of absence, etc.). *If you did not graduate, you must submit a separate, signed and dated explanation of the circumstances.*

*Complete the top portion of the "Verification of Physician Assistant Education" form contained in the application packet, and send one to each Physician Assistant program you attended. Verifications must be returned directly from the institution to this office.*

### **Question 8: Examination**

Answer "Yes" if you have passed the PANCE.  
Answer "No" if you are waiting to take the PANCE or have not taken the PANCE.

Go to the NCCPA website, <http://www.nccpa.net> and complete the "Request and Authorization & Release of Information" form. If you have taken and passed the exam, request the "Exam Results" be sent directly to this office. If you have not taken and passed the exam, request the Eligibility Letter be sent directly to this office.

### **Question 9: Licenses**

- a. If you have never held a Physician Assistant 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 a Physician Assistant license in another state or country, enter the name of that state or country here. The application has space for four licenses; if you have held more than four, additional sheets may be attached.
- b. Enter your Physician Assistant license number.
- c. Enter the date the Physician Assistant license was originally issued.
- d. Enter the date the Physician Assistant license expired or will expire.
- e. Enter "Yes" if this license is still active, "No" if it is not.

### **Question 10: Federal DEA Registration**

- a. If you have never been licensed as a Physician Assistant, enter "n/a" in this space and proceed to question 11. If you have held a Physician Assistant license in another state and were registered with the DEA while you were in that state, enter the registration number here. If you have previously held more than one DEA registration, additional sheets may be attached. b. Enter your address as listed on your DEA certificate. *Don't forget to notify the DEA of any address changes.*
- c. Enter the expiration date of your DEA registration.
- d. Enter "Yes" if this registration is active, "No" if it is not. *Send a copy of your current DEA certificate(s).*

### **Question 11: Malpractice Insurance**

- a. If you do not currently have professional liability (malpractice) insurance, enter "Pending" or "None at this time," and proceed to Question 12. If you do have malpractice insurance, enter the policy number.
- b. Enter the name of your insurance carrier.

- c. Enter the expiration date of the policy.
- d. Enter the coverage limits.

*Complete the top portion of the "Verification of Professional Liability Insurance" form included in the application packet, and send it to your insurance carrier or include a copy of your current certificate with your application.*

### **Question 12: Military Service**

- 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 13: Work History**

The application has enough space for 10 work history entries; if you need more space, additional sheets may be attached. You must enter all professional activities since the completion of Physician Assistant school. Do NOT enter "See CV;" you must complete this section even though you are attaching your curriculum vitae. If you ever took a leave of absence of more than 30 days from this employer, or if there was a gap of 30 days or more between the end of your last activity and the beginning of this one, you must provide a separate, signed and dated explanation for the time gap.

- a. Enter the mailing address of the employer. *If the facility is closed, enter the last known address.*
- b. Enter the date your employment began.
- c. Enter the date your employment ended.
- d. Enter your title or position with this employer.
- e. Enter your current status with this employer (Active or Inactive)

*Complete the top portion of the "Verification of Hospital/Clinic Physician Assistant Affiliation" and send one to the appropriate department at each hospital, clinic, group or private practice where you worked as a*

*Physician Assistant. Verifications must be returned directly from the source to this office.*

**Question 14: Physician/Professional Reference**

- a. Enter the name of one (1) physician/professional reference (not related to you). This reference must have worked with you and directly observed your work performance in the recent past. This reference cannot be the physician who will be your Supervising Physician in Arkansas. *Have this reference provide a letter of recommendation for you. The recommendation letter must be sent directly from the reference to this office.*
- b. Enter how this person is associated with you (instructor, program director, etc.).
- c. Enter the mailing address (including the organization they are with) for this reference.

**QUESTIONS 15-26 (ATTESTATION QUESTIONS):**

For each "YES" response to questions 15 through 26, 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 completely and accurately may result in disciplinary action or denial of license application.

**FOR QUESTION 15,** If you answer "yes" to this question, 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 received within 10 years prior to the date of your application and for any felony convictions. The written explanation is required for all arrests/charges or convictions. **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. Insert the applicant's name in the blank. 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

## APPLICATION FOR PHYSICIAN ASSISTANT 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 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 Parts IV of the application, you MUST submit 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.

### 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 <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic		3f. Race <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> 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)			
5c. Name of Supervising Physician		5d. Supervising Physician's Specialty	
5e. Name of Back-up Supervising Physician		5f. Back-up Supervising Physician's Specialty	

### DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Application Received: / /	Fee Received: \$	PHID No.
Temp Permit #:	Temp Issued: / /	Temp Expires: / /
PA License #:	Full License Issued:	/ /

**PART II - EDUCATION****UNDERGRADUATE EDUCATION**

List in chronological order all colleges, universities and technical schools you attended (attach additional sheets if necessary). Have each school complete and send Verification of Undergraduate Education form directly to this office.

6a. Full Name of Institution

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

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

**PHYSICIAN ASSISTANT PROGRAM**

List in chronological order all Physician Assistant Programs you attended (attach additional sheets if necessary). Have each school complete and send Verification of Physician Assistant Education form directly to this office.

7a. Full Name of Institution and Program

7b. Mailing Address (Street Address, City, State, Zip Code)

7c. Start Date

/ /

7d. End Date

/ /

7e. Graduated?

 Yes  No

7f. Degree Awarded, or reason why you did not graduate

7a. Full Name of Institution and Program

7b. Mailing Address (Street Address, City, State, Zip Code)

7c. Start Date

/ /

7d. End Date

/ /

7e. Graduated?

 Yes  No

7f. Degree Awarded, or reason why you did not graduate

**EXAMINATION HISTORY**8. Have you passed the PANCE?  Yes  No

If Yes, have certification from NCCPA mailed directly to this office.  
If No, enter date exam scheduled \_\_\_\_\_

**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 a Physician Assistant license. Attach additional sheets if necessary.

9a. Jurisdiction (State, Country)

9b. License No.

9c. Issue Date

/ /

9d. Expiration Date

/ /

9e. Active? (Yes/No)

9a. Jurisdiction (State, Country)

9b. License No.

9c. Issue Date

/ /

9d. Expiration Date

/ /

9e. Active? (Yes/No)

9a. Jurisdiction (State, Country)

9b. License No.

9c. Issue Date

/ /

9d. Expiration Date

/ /

9e. Active? (Yes/No)

9a. Jurisdiction (State, Country)

9b. License No.

9c. Issue Date

/ /

9d. Expiration Date

/ /

9e. Active? (Yes/No)

**FEDERAL DEA REGISTRATION**

If you have a Federal DEA registration as a Physician Assistant in another state, complete the following and submit a copy of your Federal DEA Registration card with your application. If you have never held a Federal DEA registration, enter "n/a."

10a. Federal DEA Registration #

10b. Your address associated with this registration

10c. Expiration Date

/ /

10d. Active? (Yes/No)

<b>PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE</b>			
If you have malpractice insurance, complete the following and submit a copy of your Certificate of Insurance. If you do not have malpractice insurance, enter "n/a" or "None."			
11a. Policy Number	11b. Insurance Carrier Name	11c. Expiration Date / /	11d. Coverage Limits
<b>MILITARY SERVICE</b>			
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.			
12a. Have you ever been in the armed forces? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, complete questions 12b-12e.</i>			
12b. Country & Branch of Service	12c. Date of Entry / /	12d. Date of Discharge / /	12e. Type of Discharge
<b>WORK HISTORY</b>			
Please provide a chronological listing of all activities, institutional affiliations or places of employment since the completion of Physician Assistant school. This includes hospitals, teaching appointments, HMOs, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. You must provide explanations of any time gaps and leaves of absence of more than 30 days since the beginning of Physician Assistant school. <b>Do not write, "See CV;" you must complete this section even though you are attaching your curriculum vitae.</b> Have each facility/entity complete and send Verification of Hospital/Clinic Affiliation form or letter directly to this office.			
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status

<b>WORK HISTORY, continued</b>			
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
13a. Name of Institution/Facility/Employer			
13b. Mailing Address (Street or PO Box, City, State, Zip Code)			
13c. Date From / /	13d. Date To / /	13e. Title/Position	13f. Status
<b>PHYSICIAN/PROFESSIONAL REFERENCE</b>		Have one (1) physician/professional with whom you have worked as a Physician Assistant mail a letter of recommendation directly to this office. This reference cannot be your Supervising Physician for Arkansas.	
14a. Name		14b. Association	
14c. Mailing Address (Organization, Street or PO Box, City, State, Zip Code)			

*CONTINUE TO PAGE 5*

## PART IV - ATTESTATION QUESTIONS

### SPECIAL INSTRUCTIONS FOR QUESTIONS 15-26

- Please mark the appropriate box next to each question. Do not leave any questions blank.
- For each "Yes" response to questions 15-26, 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 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.

15. 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 and provide official documentation.*  No  Yes
16. Do you have any physical, mental or emotional impairment? *If yes, explain.*  No  Yes
17. Have you ever been addicted to alcohol or drugs? *If yes, explain.*  No  Yes
18. Have you ever had a DWI or DUI? How many? \_\_\_\_\_ *If yes, explain.*  No  Yes
19. 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
20. Has any medical licensing board ever placed your license on probation, suspension, or has it revoked a license or certificate granted to you? *If yes, list name and address of board in your explanation.*  No  Yes
21. Have you ever been ordered to appear before a state medical board for any reason other than licensure? *If yes, explain.*  No  Yes
22. Have disciplinary procedures ever been initiated toward you by either a Medical Board or Hospital? *If yes, give name and address of board or hospital in your explanation.*  No  Yes
23. Have you ever voluntarily surrendered your license in any other state? *If yes, give name and address of board in your explanation.*  No  Yes
24. Have you ever previously made application to the Arkansas State Medical Board? *If yes, explain.*  No  Yes
25. Have any malpractice claims been filed against you? *If yes, provide official documentation from your attorney or insurance company.*  No  Yes
25. 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

*continue to next page*



**PART V - AFFIDAVIT OF APPLICANT**

I, \_\_\_\_\_, hereby certify, after being duly sworn, 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 a Physician Assistant in the State of Arkansas.

AFFIX  
PASSPORT-STYLE  
PHOTOGRAPH  
HERE

DO NOT STAPLE

\_\_\_\_\_  
**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

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

## AUTHORIZATION AND RELEASE PHYSICIAN ASSISTANT

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 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 of any confidentiality requirements that might bind you, and hereby release you from any and all liability or claims of any nature in connection with the information furnished to the Arkansas State Medical Board.

A copy of this Authorization and Release may be provided to each individual, hospital or organization where information concerning my credentials is sought and this Authorization and Release shall remain in effect until specifically revoked by me in writing.

Typed or Printed Name of Physician Assistant: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Signature of Physician Assistant: \_\_\_\_\_  
*Dark Blue or Black Ink Only - No Signature Stamps*

Signature Date: \_\_\_\_\_



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## ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

Physician Assistant

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE ANNOTATED § 17-105-101, *et seq.*, AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD.

\_\_\_\_\_  
*Physician Assistant's Full Name (First Middle Last, Suffix, Degree)*

\_\_\_\_\_  
*Physician Assistant's Signature (no rubber stamps)*

\_\_\_\_\_  
*Signature Date*

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



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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.**



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DATE OF REQUEST: \_\_\_\_\_

## VERIFICATION OF UNDERGRADUATE EDUCATION

### 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 &amp; 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 College or University (if not correct above)		
Date Education Began / /	Date Education Ended / /	Degree Awarded (ex: B.S. in Biological Sciences) <input type="checkbox"/> None
If degree was not awarded, 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? [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.]		
		<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)**



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

DATE OF REQUEST: \_\_\_\_\_

## VERIFICATION OF PHYSICIAN ASSISTANT EDUCATION

### 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 &amp; 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 Physician Assistant School (if not correct above)		
Date P.A. Education Began / /	Date P.A. Education Ended / /	Degree Awarded (ex: Master of Science in Physician Assistant Studies) <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? [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.] <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)**



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DATE OF REQUEST: \_\_\_\_\_

## VERIFICATION OF LICENSURE

### 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 &amp; 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)**





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DATE OF REQUEST: .....

## VERIFICATION OF HOSPITAL/CLINIC PHYSICIAN ASSISTANT AFFILIATION

### 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 &amp; 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 Privileges Began (including temp or provisional) / /	Date Privileges 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. Thank you.		
To the best of your knowledge, are/were the applicant's clinical privileges in good standing during the stated period of time? (if No, please attach detailed explanation)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Were the clinical privileges of this applicant ever denied, revoked, limited or suspended? (if Yes, please attach detailed explanation)		<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 www.armedicalboard.org

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

DATE OF REQUEST: \_\_\_\_\_

## VERIFICATION OF PROFESSIONAL LIABILITY INSURANCE

### 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 – APPLICANT 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	
<i>AUTHORIZATION &amp; 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 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 applicant 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 <input type="checkbox"/> Occurrence-based <input type="checkbox"/> Claims-based <input type="checkbox"/> Tail Coverage	Coverage Limits \$ _____ / \$ _____		
Have any specific procedures been excluded from this coverage? If yes, please list procedures.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your insurance company defended this provider in any professional liability suits?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your insurance company currently have any pending judgments or settlements on behalf of this provider?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your insurance company paid judgments or settlements on behalf of this provider?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>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 provider.</i>			

### 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) / /
<i>AUTHORIZATION &amp; 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

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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.*



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- 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. AR License Number
--	--	------------------------

Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. AR License Number
--	--	------------------------

Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. AR License Number
--	--	------------------------

\_\_\_\_\_  
Supervising Physician's Signature

\_\_\_\_\_  
Date Signed



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## **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*

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



# ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

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## PHYSICIAN ASSISTANT BACK-UP SUPERVISING PHYSICIAN APPLICATION

1. This form is to be filled out by each prospective Back-Up 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. Signed Arkansas Medical Practices Act and Rules & Regulations Affidavit
2. Signed Back-Up Supervising Physician Scope of Practice Statement
3. 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 Name	License No. (if applicable)
----------------------------	-----------------------------

### BACK-UP SUPERVISING PHYSICIAN INFORMATION

Back-up 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	Mobile Telephone #
-------------------------	-------------------	-----------------------	--------------------

E-mail Address	Specialty	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
----------------	-----------	--

Type or Scope of Practice
---------------------------

Services Rendered
-------------------

Area or Geographic Range of Practice
--------------------------------------

Type of Facility <input type="checkbox"/> Private Practice <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Other _____
--

### PRIMARY SUPERVISING PHYSICIAN(S) INFORMATION

Primary Supervising Physician	Medical License Number
-------------------------------	------------------------

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



**PHYSICIAN ASSISTANTS CURRENTLY UNDER YOUR SUPERVISION**

Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. AR License Number
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. AR License Number
Name of Physician Assistant currently under your supervision	Supervising or Back-up Supervising? <input type="checkbox"/> Supervising <input type="checkbox"/> Back-up	P.A. AR License Number

---

Supervising Physician's Signature

---

Date Signed

---

Back-up Supervising Physician's Signature

---

Date Signed



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## **ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT**

**(Back-up 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.

\_\_\_\_\_  
*Back-Up Supervising Physician's Full Name (First Middle Last, Suffix, Degree)*

\_\_\_\_\_  
*Back-Up Supervising Physician's Signature (no rubber stamps)*

\_\_\_\_\_  
*Signature Date*

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LITTLE ROCK, AR 72201**



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## **BACK-UP SUPERVISING PHYSICIAN SCOPE OF PRACTICE STATEMENT**

**Regulation 24(7)(D) states:**

The supervising physician and back-up supervising physician must be skilled and trained in the same scope of practice as the tasks that have been assigned to and will be performed by the Physician Assistant that they supervise.

**I have reviewed the protocol of this Physician Assistant. My scope of practice and/or training is similar to the Supervising Physician and I feel that I can supervise this Physician Assistant in the absence of the Supervising Physician.**

---

*Back-Up Supervising Physician's Full Name (First Middle Last, Suffix, Degree)*

---

*Back-Up Supervising Physician's Signature (no rubber stamps)*

---

*Signature Date*

---

*Physician Assistant's Full Name*

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

Must be on Facility Letterhead  
(Today's Date)

In compliance with Statute 17-105-101, a copy of this agreement will be kept on file at all Arkansas practice sites and with the Arkansas State Medical Board. This agreement will go into effect \_\_\_\_\_ (list date here). It will be updated as necessary to reflect changes in the practice.

Physician Assistant Protocol and Delegation of Services Agreement for \_\_\_\_\_ (Name of P.A.)

Name of Facility  
Address of Facility  
Phone Number of Facility  
Fax Number of Facility

**LIST ALL LOCATIONS THE P.A. WILL WORK**

Supervising Physician: \_\_\_\_\_

License #: \_\_\_\_\_

\*Back-up Supervising Physician(s): \_\_\_\_\_

License #: \_\_\_\_\_

\*Add additional lines/pages  
if needed

\_\_\_\_\_  
\_\_\_\_\_

License #: \_\_\_\_\_

License #: \_\_\_\_\_

Services to be performed by Physician Assistant in the medical practice of the above-referenced physicians:  
(Be specific in your list as indicated below)

- Obtain chief complaint
- Obtain history
- Perform physical
- Order diagnostic testing
- Develop problem list
- Formulate and institute care plan
- Patient education
- Patient follow-up
- Hospital Rounds (if PA will be making hospital rounds, specify the name of facility—if not, remove this entry)

**LIST ONLY THE SERVICES  
AND PROCEDURES THAT  
YOU ACTUALLY PERFORM-  
REMOVE THE PROCEDURES  
YOU DO NOT PERFORM**

Procedures to be performed by Physician Assistant in the medical practice of the above-referenced physicians:  
(Be specific in your list as indicated in the example below)

- Start IV's
- Venipunctures
- Suture simple wounds (no tendon, vascular, nerve injuries)
- Medical injections (SPECIFY WHERE ADMINISTERED, AND CLASS OF DRUGS- i.e. Intra-articular, Intramuscular or Subcutaneous)
- Application of splints
- Incision and drainage of superficial abscesses such as infected sebaceous cysts
- Nasogastric tube placement
- Placement of urinary catheter
- Wound debridement and dressing changes
- Anoscopy (if P.A. will NOT be doing, remove from protocol)
- Pap Smears
- Joint injections/aspirations (SPECIFY LOCATION-i.e., elbow, wrist, knee, etc).
- Preliminary interpretation of X-rays, EKG's with final interpretation to be done by Physician

**Procedures requiring on-site physician supervision: (BE SPECIFIC IN YOUR LIST)**

- List these procedures

**Medications to be prescribed by the Physician Assistant: (Pending DEA and ASMB approval)**

- All non-controlled medications with the following exceptions:
  - Chemotherapeutic agents
  - Immunosuppressive agents with the exception of steroids
  - Thrombolytic agents
- Controlled medications within Schedules III, IV, and V

**Type and frequency of supervision by the Supervising Physician:**

The Physician Assistant's delegated scope of practice has the following restrictions: activities in which diagnosis, treatment or management exceeds the Physician Assistant's level of competence, training or skill or is outside the scope of the physician's level.

The Supervising Physician or his Back-up Supervising Physician will be on-site or available at all times to the Physician Assistant. One of these physicians will be within a driving radius of 60 minutes of the Physician Assistant and would always be available by phone.

The Physician Assistant will not practice if the Supervising Physician and/or the Back-up Supervising Physician is physically absent, not physically available within 60 minutes, or available by phone.

**Process of Evaluation by Supervising Physician and Back-up Supervising Physician:**

- 100% review and countersign the documentation of all Physician Assistant patient encounters within the first 120 days of employment.
- Following the first 120 days of employment, the Supervising Physician will review and countersign a minimum of 10% (or more as specified in the protocol) of all Physician Assistant patient encounters in the clinic setting
- 100% review and countersign of all inpatient Physician Assistant patient encounters in compliance with the bylaws and rules and regulations of (NAME OF FACILITY/HOSPITAL IF APPLICABLE).
- 100% review of all procedures performed by the Physician Assistant within the first 120 days of employment.

Local ambulance service will be used to transport medical emergencies when Supervising Physician or Back-up Supervising Physician is not on-site. Progress notes written by the Physician Assistant for patients who require hospital admission or transfer to the emergency department of the local hospital will be countersigned by the Supervising Physician within 24 hours.

**Printed Name of PA:** \_\_\_\_\_

**Signature of PA:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name of Supervising Physician:** \_\_\_\_\_

**Signature of Supervising Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name of Back-Up Supervising Physician:** \_\_\_\_\_

**Signature of Back-Up Supervising Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name of Back-Up Supervising Physician:** \_\_\_\_\_

**Signature of Back-Up Supervising Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Printed Name of Back-Up Supervising Physician:* \_\_\_\_\_

*Signature of Back-Up Supervising Physician:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*(Add additional lines for additional Back-Up Supervising Physicians if needed)*

EXAMPLE

*Arkansas State Medical Board:*

*Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Chairman, Physician Assistant Advisory Committee*

EXAMPLE

**Board Seal**