



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

1401 West Capitol, Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org

Susan Wyles, R.A. Licensing Coordinator, (501) 296-1955, swy@armedicalboard.org

RADIOLOGIST ASSISTANT LICENSURE INFORMATION PACKET

This packet contains all of the documents you will need to apply for a license in Arkansas. This packet, as well as each of its components, is available in the Forms & Publications section of our web site, www.armedicalboard.org/forms.aspx. 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from a source other than directly from the Arkansas State Medical Board or its official website, the application may be outdated or not an official version. Please be advised that outdated or unofficial versions of the application cannot be accepted.

*** IMPORTANT INFORMATION - PLEASE READ CAREFULLY ***

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 radiologist assistant license has been granted. Applications are processed in the order in which they are received in our office. The board does NOT accelerate one applicant over another. Upon receipt of your completed application, it will be entered into our system and then routed to the Licensing Coordinator.

APPLICATION FEES. The fee for full licensure is **\$75.00**, 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.

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 radiologist 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 in the Forms & Publications section of our web site, www.armedicalboard.org.

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. 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.

COMPLETING THE APPLICATION. READ THE INSTRUCTIONS FOR EACH QUESTION BEFORE ANSWERING. The application may NOT be submitted electronically, 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," or "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.

TIME GAPS. Any time gaps of more than 30 days since the beginning of Radiologist Assistant school must be explained in writing. You will be notified of any unexplained time gaps and asked to provide an explanation. To avoid processing delays, please include these with your original application.

"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 question in the application, 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.

VERIFICATIONS. It is the policy of this board that ALL education, training, and professional affiliations and other activities since graduation from Radiologist Assistant School be verified by the primary source and reviewed by the full board prior to issuance of a permanent license. It is the applicant's responsibility to request verifications and to follow up with organizations to ensure verifications are returned. All verifications will be accepted via fax or e-mail unless specifically requested to be mailed to the address on page 6. 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.

CHECKING THE STATUS OF YOUR APPLICATION. The Arkansas State Medical Board's preferred form of communication is an interactive Applicant Checklist system that allows communication between us via the web. We have found that this system is a very effective communication tool and significantly reduces the time to licensure. You may access the Applicant Checklist system from any computer at any time by visiting the Medical Board's web site at: <http://www.armedicalboard.org>. You will click the "Applicant Checklist" link, located on the left, to access this secured web address. You must enter a FileID which will be provided to you via e-mail once work on your application has started. You will also need your date of birth and the last 4 digits of your SSN to access this secure system.

Be sure to review the "How to Use the Checklist System" once you have successfully logged into the site.

When using the system, specific information for each item on your application is visible to you. If a verification or another piece of requested information has arrived and is accurate and complete, a check mark will appear next to it notifying you that it is acceptable. If it is incomplete, a different visual indicator will appear next to that item indicating that item needs action/follow up. Additional information will be provided to you in the communication that is posted there for you to read. Please review this information by clicking the Yellow "Unread Message" indicator next to the element. When the action has been taken and the information is received and complete, a check mark will appear next to it notifying you that it, too, is acceptable.

This interactive system allows the licensing coordinators 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.

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. **THE BOARD DOES NOT ACCELERATE ONE APPLICANT OVER ANOTHER.**

COMMITTEE APPEARANCE. All applicants and supervising radiation practitioners will be required to appear before the ASMB Radiologist Assistant Advisory Committee prior to licensure, and also when there is a change of supervising radiation practitioners. 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 and completed application deadlines will be provided to you by your Licensing Coordinator and are available on our web site, www.armedicalboard.org. Completed application deadlines will be provided to you by your Licensing Coordinator.

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.

INACTIVE APPLICATIONS. Applications which are not complete after one year will be classified as Inactive and will be removed from our system. Inactive files will be maintained for 30 days and then destroyed. No refunds will be given on inactive applications over one year old.

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.

LICENSE RENEWAL. Your Radiologist 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 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 Radiologist Assistant in this State with an inactive or lapsed license or permit.**

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 included in this packet and is available for download at our website www.armedicalboard.org in the Forms and Publications section. **THIS ADDRESS CHANGE MUST BE IN WRITING.**

RADIOLOGIST ASSISTANT REQUIREMENTS FOR MEDICAL LICENSURE IN ARKANSAS

ARKANSAS MEDICAL PRACTICES ACTS REGULATION 29:

IN ORDER TO OBTAIN SAID PERMIT THE RA OR RPA MUST COMPLY WITH THE FOLLOWING:

- (1) Complete and submit an application and provide such information as the Board requires.
- (2) Provide proof of successfully passing the Registered Radiologist Assistant Examination by the American Registry of Radiologic Technologist, or provide proof of licensure in Arkansas by 2007 as an RA or RPA through the Division of Ionizing Radiation at the Arkansas State Department of Health.
- (3) Be at least 18 years of age.
- (4) Provide the names and signatures of the supervising and alternate supervising radiation practitioners licensed to practice in the State of Arkansas who agree to supervision of the RA or RPA under the terms of these Rules and Regulations.
- (5) Provide a practice-specific document delineating the specific procedures and tasks to be performed by the RA or RPA in each facility utilized, including the level of supervision to be provided by the supervising licensed radiation practitioners.
- (6) Pay a licensure fee of \$75.00 to the Board with the application for the initial permit. The supervising and alternate supervising radiation practitioners must sign the application form that they have read the Rules and Regulations and will abide by same, including disciplinary actions pertaining to the RA or RPA and themselves.

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:

- Registered Radiologist Assistant (RRA) Examination

ARKANSAS STATE MEDICAL BOARD:

- Joseph M. Beck, II, M.D., Chairman
- Peggy Pryor Cryer, Executive Secretary
- Business Hours: Monday-Friday 8:00 AM - 5:00 PM
- Regulatory Phone: (501) 296-1802
- Regulatory Fax: (501) 296-1805
- Mailing and Physical Address: 1401 W. Capitol, Suite 340
Little Rock, AR 72201

RADIOLOGIST ASSISTANT LICENSING COORDINATOR:

Susan Wyles
Phone: (501) 296-1955
Fax: (501) 296-1805
E-mail: swy@armedicalboard.org

ARKANSAS STATE MEDICAL BOARD WEB SITE: WWW.ARMEDICALBOARD.ORG

- Click on Forms & Publications to access the following at any time:
 - Arkansas Medical Practices Act and Rules and Regulations
 - Application packet, including all required forms, and verification request forms
- License Verifications
- Board Meeting Dates
- Changes in Rules and Regulations

CURRENT FEES:

- Full License - \$75.00
- Annual License Renewal - \$50.00
- Late Renewal Fee - \$25.00

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: SUSAN WYLES
1401 W. Capitol, 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 \$75.00.
- Application (6 pages), signed, with photo and certification by Notary Public. Signature must be original and must be made in black or dark blue ink. Stamped signatures, signatures by proxy and signatures by Power of Attorney are NOT accepted.
- 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
- Completed Radiologist Assistant Authorization and Release (form in packet)
- Completed Arkansas Medical Practices Acts and Rules and Regulations Affidavit (form in packet)
- Completed Secondary Contact Designation (form in packet)
- Current Curriculum Vitae (CV)
- Copy of Driver's License or Passport
- Copy of name change documents, if applicable
- Copy of proof of citizenship, naturalization, visa, or work permit, if applicable (*if not born in the U.S.*)
- Copy of DD Form 214 (Certificate of Release or Discharge from Active Duty), if you have served in any branch of the U.S. Armed Forces at any time during or since Medical School

YOU are required to request the following documents from their primary sources, and these documents must be sent from the primary source directly to the Arkansas State Medical Board:

- Verification of Radiologist Assistant Education and Official Transcript** (form in packet)
Complete the top portion of this form, sign, and then send a copy to the Dean or Registrar of each Radiologist Assistant school you attended.
- ARRT Registered Radiologist Assistant Examination Results/Eligibility**
Go to www.rrt.org. If you have taken and passed the RRA exam, have certification from ARRT mailed directly to this office. If you have not taken the exam, send a notarized copy of your verification to sit for the next exam.
- Verification of Licensure** (form in packet)
The applicant is no longer required to request verification of their out-of-state Radiologist Assistant licenses, except for those states that do not provide free, online verification through their website (MS, MA, NJ and ND, 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 Radiologist 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 Radiologist Assistant privileges or employed you as a Radiologist 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**
Court documents are no longer required for malpractice cases. If the case is settled, the NPDB report will suffice. However, the applicant still will be required to submit a signed narrative of the case, as well as having the attorney send a narrative of the case, or have the insurance company send a claims history report.
- Verification of Military Service** (form in packet) - If you are still in the armed forces, send with a copy of the Radiologist Assistant Authorization and Release form (also in this packet) to your Commanding Officer at your current duty station. If you are former military, you only need to provide a copy of your DD214.
- Supervising Radiation Practitioner Application** (form in packet)
Send to your Supervising Radiation Practitioner for completion.
- Alternate Supervising Radiologist Application** (form included in packet)
Send to your Alternate Supervising Radiologist for completion.
- Professional Reference/Recommendation Letters**
Only one (1) letter of recommendation is required. It cannot be from a physician who will be your supervising Radiation Practitioner 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 must be addressed to the Arkansas State Medical Board and be mailed directly to the Board, stating that they are recommending you for licensure in Arkansas.
 - 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 have personal comments about the applicant.
 - 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. *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 foreign-born but a citizen of the U.S., 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 or months that you have lived in the U.S. If you are a U.S. citizen, enter "n/a".

Question 4: Your Contact Information

- Enter your Public mailing address. 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. 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 email address is required, as it will carry over toward the 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 Radiation Practitioner. If you have not found employment at the time of application, enter "pending."

- Enter your Supervising Radiation Practitioner's specialty. Please note that, per Regulation 29, *"Supervising and alternate supervising radiation practitioners must have the privileges to perform the procedures for which he/she is supervising for the RA or RPA. If it is an invasive procedure, the radiation practitioners must satisfy, at a minimum, the same educational and experience requirements as the RA or RPA."*
- Enter the name of the physician that will be your Alternate Supervising Radiologist.
- Enter your Alternate Supervising Radiologist's specialty.

Question 6: Undergraduate Education

- Enter the full name of the college or university and program where you completed your Radiologist Assistant or Radiology Practitioner Assistant 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. *Complete the top portion of the "Verification of Radiologist Assistant Education" form contained in the application packet, and send one to each program you attended. Forms must be returned directly to this office from the institution.*
- Enter the mailing address of the program.
- Enter the date you started attending the program.
- Enter the date you left the program (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.*

Question 7: Examination

Answer "Yes" if you passed the ARRT examination, "No" if you did not. *If you have taken and passed the exam, have certification from ARRT mailed directly to this office. If you have not taken and passed the exam, send a notarized copy of your verification to sit for the next exam.*

Question 8: Licenses

- If you have never held an RA or RPA 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 RA or RPA 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.
- Enter your RA or RPA license number.
- Enter the date the RA/RPA license was originally issued.

- d. Enter the date the RA/RPA license expired or will expire.
- e. Enter "Yes" if this license is still active, "No" if it is not.

Question 9: Military Service

- a. Answer "Yes" if you've ever served in the armed forces of the U.S. or any other country during or since Radiologist Assistant School. Answer "No" if you have not. *If yes, send a copy of your separation papers (DD Form 214) with your application. If Active Duty or Active Reserves, complete the top portion of the "Verification of Military Service" and send it to the Commanding Officer at your current duty station. Verifications must be returned directly 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. Enter the name of the employer. The application has enough space for 5 entries; if you need more space, additional sheets may be attached. 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. Complete the top portion of the "Verification of Hospital/Clinic Radiologist Assistant Affiliation" and send one to the appropriate department at each hospital, clinic, group or private practice where you worked as a Radiologist Assistant. 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.*
- 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)
Locum Tenens – The locum tenens company can provide a list of all of the applicant's assignments with

exact dates, and the Board no longer requires verification from each assignment facility.

Question 11: Professional Reference

- a. Enter the name of one (1) professional reference (not related to you). This reference must have worked with you and directly observed your work performance in the recent past or have had organization responsibility for supervising your performance (i.e., department chief or training program director). *Have the 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 12-23 (ATTESTATION QUESTIONS):

For each "YES" response to questions 12 through 23, you must provide a separate, signed and dated statement giving full details, including date, location, type of action, organization or parties involved, and specific circumstances. If you are not sure how to respond to a question, it is best to disclose all information and provide an explanation. Failure to answer these questions accurately may result in disciplinary action or denial of license application.

FOR QUESTION 12, you must attach copy of original indictment, judgment or conviction, indicate whether paroled or placed on probation, and how probation was completed. If you have or had a record that was sealed, expunged or pardoned, you are still required to answer "Yes" to this question and provide documentation.

Affidavit of Applicant (Signature Page):

Read the affidavit completely before signing. Attach a recent photograph 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 partially on the photograph. *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

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

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Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org

Susan Wyles, R.A. Licensing Coordinator, (501) 296-1955, swy@armedicalboard.org

APPLICATION FOR RADIOLOGIST 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.
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 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)	
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 Radiation Practitioner		5d. Supervising Radiation Practitioner's Specialty	
5e. Name of Alternate Supervising Radiologist		5f. Alternate Supervising Radiologist's Specialty	

PART II - EDUCATION**RADIOLOGIST ASSISTANT PROGRAM**

List in chronological order all Radiologist Assistant Programs you attended (attach additional sheets if necessary). Have each school complete and mail Verification of Radiologist Assistant Education form 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 HISTORY7. Have you passed the American Registry of Radiologic Technologists Exam? Yes No

If Yes, have certification from ARRT mailed directly to this office.
If No, send a notarized copy of your verification to sit for the next exam.

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 Radiologist Assistant license. 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 (DD214) with your application. If Active Duty, have your Commanding Officer complete and mail the Verification of Military Service sent directly to this office.

9a. Have you ever been in the armed forces? 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 medical and non-medical work history and other activities, including hospitals, private practice, employment, time gaps and leaves of absence since graduation from Radiologist Assistant or Radiology Practitioner Assistant program. **You must provide explanations of any time gaps and leaves of absence of more than 30 days since the start of Radiologist Assistant School. Do not write, "See CV;" you must complete this section even though you are attaching your curriculum vitae.**

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
PROFESSIONAL REFERENCE		Have one (1) professional reference mail a letter of recommendation directly to this office. This reference cannot be related to you. They must have worked with you and directly observed your work performance in the recent past or have had organization responsibility for supervising your performance (i.e., department chief or training program director).	
11a. Name		11b. Association	
11c. Mailing Address (Organization, Street or PO Box, City, State, Zip Code)			

PART IV - ATTESTATION QUESTIONS

SPECIAL INSTRUCTIONS FOR QUESTIONS 12-23

- Please mark the appropriate box next to each question. Do not leave any questions blank.
- For each "Yes" response to questions 12-23, 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.

12. 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
13. Do you have any physical, mental or emotional impairment? *If yes, explain.* No Yes
14. Have you ever been addicted to alcohol or drugs? *If yes, explain.* No Yes
15. Have you ever had a DWI or DUI? How many? _____ *If yes, explain.* No Yes
16. 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
17. 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
18. Have you ever been ordered to appear before a state licensing board for any reason other than licensure? *If yes, explain.* No Yes
19. Have disciplinary procedures ever been initiated toward you by either a licensing board or hospital? *If yes, give name and address of board or hospital in your explanation.* No Yes
20. Have you ever voluntarily surrendered your license in any other state? *If yes, give name and address of board in your explanation.* No Yes
21. Have you ever previously made application to the Arkansas State Medical Board? *If yes, explain.* No Yes
22. Have any malpractice claims been filed against you? *If yes, provide official documentation from your attorney or insurance company.* No Yes
23. 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 Radiologist 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 overlie a portion of the photograph at left)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

APPLICATION RECEIVED: ____ / ____ / ____ FEE RECEIVED: \$ _____ DATE: ____ / ____ / ____

RADIOLOGIST ASSISTANT LICENSE #: _____ FULL LICENSE ISSUED: ____ / ____ / ____

APPROVAL SIGNATURE: _____ SIGNATURE DATE: _____



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

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

Phone (501) 296-1802 www.armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

Radiologist Assistant

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE 17-106-201, *et seq.*, AND THE RULES AND REGULATION 29 OF THE ARKANSAS STATE MEDICAL BOARD.

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

Radiologist 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.**

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



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

1401 West Capitol, Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org

Susan Wyles, R.A. Licensing Coordinator, (501) 296-1955, swy@armedicalboard.org

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

RADIOLOGIST ASSISTANT AUTHORIZATION AND RELEASE

To Whom It May Concern:

This document will authorize and direct any physicians with whom I have been associated, employees and medical staff members of any medical facility or hospital where I have been employed or on staff or associated, or any employees of any malpractice insurance carriers, or any state medical licensing boards where I have been licensed or have applied for a license, or any medical clinics where I have been employed or associated, or any colleges, universities, or radiologist assistant schools that I have attended, or other individuals with whom I have been associated, 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, medical charges that I have made and evaluations of my performance.

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 Radiologist Assistant: _____

Social Security Number: _____

Signature of Radiologist Assistant: _____

Dark Blue or Black Ink Only - No Signature Stamps

Signature Date: _____



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

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

Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org

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

SECONDARY CONTACT DESIGNATION FORM

So that the licensing process might be made easier for both you and the Board, your Licensing Coordinator will communicate with you and ONE other person of your choice regarding the status of your licensure application. However, please advise your designated contact that your Licensing Coordinator is working with several other allied health 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.

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

Email address of Secondary Contact

Phone number of Secondary Contact

Print full name of Applicant

Signature of Applicant (no signature stamps)

Date Signed

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.



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

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

Phone (501) 296-1802 www.armedicalboard.org

RADIOLOGIST ASSISTANT SUPERVISING RADIATION PRACTITIONER APPLICATION

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

RADIOLOGIST ASSISTANT

Radiologist Assistant's Name

SUPERVISING RADIATION PRACTITIONER INFORMATION

Supervising Radiation Practitioner Name			License Number
Complete 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 <input type="checkbox"/> Private Practice <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Other _____			

ALTERNATE SUPERVISING RADIOLOGIST INFORMATION (attach additional sheets if necessary)

Alternate Supervising Radiologist #1			License Number
Complete Address (PO Box or Street, City, State, Zip Code)			
When will Alternate Supervising Radiologist be utilized?			
Alternate Supervising Radiologist #2			License Number
Complete Address (PO Box or Street, City, State, Zip Code)			
When will Alternate Supervising Radiologist be utilized?			

Continue to next page

RADIOLOGIST ASSISTANTS CURRENTLY UNDER YOUR SUPERVISION

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

IMPORTANT INFORMATION

THE FOLLOWING ITEMS MUST BE INCLUDED WHEN SUBMITTING THIS APPLICATION.

- 1. Arkansas Medical Practices Act and Rules and Regulations Affidavit, signed by Supervising Radiation Practitioner.**
- 3. Copy of Supervising Radiation Practitioner’s Federal DEA registration certificate.**
- 4. Copy of Supervising Radiation Practitioner’s current professional liability insurance certificate.**
- 5. Signed practice specific document.**

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

Supervising Radiation Practitioner’s Signature
(must be signed in the presence of a Notary Public)

Date Signed

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

this _____ day of _____, 20_____.

My commission expires: _____

Notary Signature

(Notary Seal)



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

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

Phone (501) 296-1802 www.armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

Supervising Radiation Practitioner

I AFFIRM THAT I HAVE READ THE RADIOLOGY ASSISTANT ACT, ARKANSAS CODE 17-106-201, *et seq.*, THE MEDICAL PRACTICES ACT 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 Radiation Practitioner's Full Name (First Middle Last, Suffix, Degree)

Supervising Radiation Practitioner's Signature (no rubber stamps)

Signature Date

**THIS IS A REQUIREMENT FOR LICENSURE.
YOU MUST COMPLETE THIS FORM AND RETURN IT TO:**

**ARKANSAS STATE MEDICAL BOARD
ATTN: R.A. LICENSING COORDINATOR
1401 W. Capitol, Suite 340
LITTLE ROCK, AR 72201**



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

2100 Riverfront Drive, Little Rock, AR 72202-1747

Phone (501) 296-1802 www.armedicalboard.org

RADIOLOGIST ASSISTANT - PRACTICE SPECIFIC DOCUMENT

Print Applicant's Name _____

Print Supervising Radiation Practitioner's Name _____

PART I: CLINICAL ACTIVITIES AND SUPERVISION DEFINITIONS

Clinical Activities that may be performed:

1. Reviewing the patient's medical record to verify the appropriateness of a specific exam or procedure.
2. Interviewing the patient to obtain, verify, and update medical history.
3. Explaining the procedure to the patient, significant others or other care providers including a description of risks, benefits, alternatives, and follow-up.
4. Obtain informed consent. Patient must be able to communicate with the Supervising Radiation Practitioner or Alternate Supervising Radiologist if he/she requests or if any questions arise that cannot be appropriately answered by the radiologist assistant.
5. Determining patient compliance, if needed, with pre-examination preparation instructions (e.g., diet, medications).
6. Assessing risk factors that may contraindicate the procedure (e.g., health history, medications, pregnancy, psychological indicators, and alternative medicines).
7. Obtaining and evaluating vital signs.
8. Performing physical examinations and analysis of date (e.g., signs and symptoms, laboratory values, and significant abnormalities) and reporting findings to the supervising radiation practitioner.
9. Reviewing electrocardiogram (ECG) and recognizing life-threatening abnormalities.
10. Performing urinary catheterization.
11. Performing venipuncture.
12. Monitoring IV therapy for flow rate and complications.
13. Positioning the patient to perform the required procedure, using immobilization devices and modifying technique as necessary and in compliance with any regulations, policies, or standards.
14. Observing and assessing the patient who has received conscious sedation under the direct or personal supervision of the Supervising Radiation Practitioner or Alternate Supervising Radiologist and according to institutional policy.
15. Assessing the patient's level of anxiety or pain and informing Supervising Radiation Practitioner or Alternate Supervising Radiologist as appropriate.
16. Recognizing and responding to medical emergencies (e.g., drug reactions, cardiac arrest and hypoglycemia) activating emergency response systems, and notifying appropriate personnel.

Print Applicant's Name _____

Print Supervising Radiation Practitioner's Name _____

17. Administering oxygen as prescribed.
18. Operating a fluoroscopic unit.
19. Documenting fluoroscopy time.
20. Explaining the effects and potential adverse effects to the patient of the pharmaceutical required for the examination.
21. Administering contrast media as prescribed by the Supervising Radiation Practitioner or Alternate Supervising Radiologist.
22. Administering other non-narcotic medications (e.g., antibiotics, anticoagulant therapy, anti-emetics, etc.) ordered by the Supervising Radiation Practitioner or Alternate Supervising Radiologist or patient's clinical doctor but only under the direct or personal supervision of the Supervising Radiation Practitioner or Alternate Supervising Radiologist.
23. Monitoring the patient for adverse effects of the pharmaceutical.
24. Reviewing imaging procedures, making initial observations, and communicating imaging and clinical observations only to the Supervising Radiation Practitioner or Alternate Supervising Radiologist.
25. Recording previously communicated initial observations of imaging procedures according to protocols.
26. Communicating the Supervising Radiation Practitioner or Alternate Supervising Radiologist's report to the referring physician consistent with American College of Radiology Communication Guideline.
27. Providing physician-prescribed post-procedure care instructions to patients.
28. Performing follow-up patient evaluation and communicating findings to the Supervising Radiation Practitioner or Alternate Supervising Radiologist.
29. Documenting the procedure in the appropriate records and noting exceptions for protocol or procedure.
30. Providing patient discharge summary for review and co-signature by the Supervising Radiation Practitioner or Alternate Supervising Radiologist.
31. Participating in quality improvement activities within the radiology practice (e.g., quality of care, patient flow, reject-repeat analysis, patient satisfaction).
32. Assisting with data collection and review for clinical trials or other research.

Definition of Levels of Supervision:

1. *General Supervision* means the procedure is furnished under the Supervising Radiation Practitioner or Alternate Supervising Radiologist's overall direction and control, but the Supervising Radiation Practitioner or Alternate Supervising Radiologist's presence is not required during the performance of the procedure.
2. *Direct Supervision* means the Supervising Radiation Practitioner or Alternate Supervising Radiologist must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. The Supervising Radiation Practitioner or Alternate Supervising Radiologist is not required to be present in the room when the procedure is performed.
3. *Personal Supervision* means the Supervising Radiation Practitioner or Alternate Supervising Radiologist must be in attendance in the room during the performance of the procedure.

Print Applicant's Name _____

Print Supervising Radiation Practitioner's Name _____

PART II - PROCEDURES

For each procedure the Radiologist Assistant intends to perform, list the number of documented procedures already performed by the Radiologist Assistant in the last five (5) years. Indicate the level of supervision requested (**General, Direct, or Personal**). **All invasive procedures require a minimum of direct supervision.**

Procedures to be Performed	Documented Cases Performed	Supervision Requested (Gen, Dir, Per)	Supervision Granted (Gen, Dir, Per)
<p>1. Non-Invasive Procedures Perform non-invasive imaging procedures under the supervision of the Supervising Radiation Practitioner or Alternate Supervising Radiologist.</p> <p>A. Gastrointestinal Studies</p> <ol style="list-style-type: none"> 1. Contrast Enemas (single and double contrast) 2. Upper GI series 3. Small Bowel series 4. Barium Swallowing Studies 5. Esophagram 6. Sinus Tract Fistulagram 7. Nasogastric tube replacement & repositioning <p>B. Urogenital Studies</p> <ol style="list-style-type: none"> 1. Cystography 2. Nephrostogram 3. Voiding Cystourethrogram 4. Loopogram 5. Intravenous urography <p>C. Biliary System</p> <ol style="list-style-type: none"> 1. T-tube cholangiogram 	<p>A. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ <p>B. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ <p>C. _____</p> <ol style="list-style-type: none"> 1. _____ 	<p>A. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ <p>B. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ <p>C. _____</p> <ol style="list-style-type: none"> 1. _____ 	<p>A. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ <p>B. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ <p>C. _____</p> <ol style="list-style-type: none"> 1. _____

Print Applicant's Name _____

Print Supervising Radiation Practitioner's Name _____

For each procedure the Radiologist Assistant intends to perform, list the number of documented procedures already performed by the Radiologist Assistant in the last five (5) years. Indicate the level of supervision requested (**Direct or Personal**). **All invasive procedures require a minimum of direct supervision.**

Procedures to be Performed	Documented Cases Performed	Supervision Requested (Dir or Per)	Supervision Granted (Dir or Per)
<p>2. Invasive Procedures Perform invasive imaging procedures under the supervision of the Supervising Radiation Practitioner or Alternate Supervising Radiologist.</p> <p>A. Venous Access - Placement</p> <ol style="list-style-type: none"> 1. PICC placement 2. Non-Tunneled Central Venous Access 3. Tunneled Central Venous Access 4. Venous Port placement <p>B. Venous Access - Removal</p> <ol style="list-style-type: none"> 1. PICC line removal 2. Non-Tunneled CVL removal 3. Tunneled CVL removal 4. Venous Port removal 5. Intravenous urography <p>C. Fluid Aspiration Procedures</p> <ol style="list-style-type: none"> 1. Paracentesis 2. Thoracentesis 3. Superficial fluid collections 4. Abscess tube placement 5. Pleural drain placement <p>D. Angiography</p> <ol style="list-style-type: none"> 1. Basic Femoral Venous non-selective Sheath Placement 2. Basic Femoral Arterial non-selective Sheath Placement 3. Perform non-selective aorto-iliac arteriography 4. Perform non-selective Venography 5. Assist The Supervising Radiation Practitioner or Alternate Supervising Radiologist with Arterial/Venous interventional procedures (e.g., selective catheterization, percutaneous angioplasty, vascular stent placement, etc.) 	<p>A. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ <p>B. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ <p>C. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ <p>D. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 	<p>A. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ <p>B. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ <p>C. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ <p>D. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 	<p>A. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ <p>B. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ <p>C. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ <p>D. _____</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Print Applicant's Name _____

Print Supervising Radiation Practitioner's Name _____

For each procedure the Radiologist Assistant intends to perform, list the number of documented procedures already performed by the Radiologist Assistant in the last five (5) years. Indicate the level of supervision requested (**Direct or Personal**). **All invasive procedures require a minimum of direct supervision.**

Procedures to be Performed	Documented Cases Performed	Supervision Requested (Dir or Per)	Supervision Granted (Dir or Per)
E. Drainage tube management/maintenance (Catheter Check/Change of Drainage Tubes) 1. Gastrointestinal Tubes (e.g., Gastrostomy, Gastrojejunostomy, Jejunostomy, etc.) 2. Genitourinary Tubes (Nephrostomy, etc.) 3. Abscess Drainage Tubes 4. Biliary Drainage Tubes (Internal, Internal/External, etc.)	E. _____ 1. _____ 2. _____ 3. _____ 4. _____	E. _____ 1. _____ 2. _____ 3. _____ 4. _____	E. _____ 1. _____ 2. _____ 3. _____ 4. _____
F. Drainage tube management/maintenance (Catheter Check/Change of Drainage Tubes) 1. Simple Suturing & Retention Device Suturing 2. Dressing Changes 3. Drainage Bag Management/Evaluation	F. _____ 1. _____ 2. _____ 3. _____	F. _____ 1. _____ 2. _____ 3. _____	F. _____ 1. _____ 2. _____ 3. _____
G. Joint Aspiration and Lumbar Puncture 1. Arthrography a. Shoulder b. Knee c. Hip d. Wrist e. Elbow f. Ankle 2. Neuroradiology a. Lumbar puncture b. Lumbar myelography c. Thoracic Myelography d. Cervical Myelography e. Epidural Steroid injection	G. _____ 1a. _____ b. _____ c. _____ d. _____ e. _____ f. _____ 2a. _____ b. _____ c. _____ d. _____ e. _____	G. _____ 1a. _____ b. _____ c. _____ d. _____ e. _____ f. _____ 2a. _____ b. _____ c. _____ d. _____ e. _____	G. _____ 1a. _____ b. _____ c. _____ d. _____ e. _____ f. _____ 2a. _____ b. _____ c. _____ d. _____ e. _____

Print Applicant's Name _____

Print Supervising Radiation Practitioner's Name _____

For each procedure the Radiologist Assistant intends to perform, list the number of documented procedures already performed by the Radiologist Assistant in the last five (5) years. Indicate the level of supervision requested (**Direct** or **Personal**). **All invasive procedures require a minimum of direct supervision.**

Procedures to be Performed	Documented Cases Performed	Supervision Requested (Dir or Per)	Supervision Granted (Dir or Per)
H. Image guided biopsies performing ultrasound, CT, or fluoroscopic guided biopsies and aspirations 1. Bone/Bone Marrow 2. Liver 3. Lung 4. Soft Tissue 5. Breast 6. Kidney 7. Pancreas 8. Thyroid	H. _____ 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____	H. _____ 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____	H. _____ 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____
Additional Procedures I. _____ II. _____ III. _____ IV. _____ V. _____	I. _____ II. _____ III. _____ IV. _____ V. _____	I. _____ II. _____ III. _____ IV. _____ V. _____	I. _____ II. _____ III. _____ IV. _____ V. _____

Each procedure must be performed under the supervision of a Supervising Radiation Practitioner or Alternate Supervising Radiologist, who must have institutional clinical privileges for the procedure performed by the Radiologist Assistant. The Radiologist Assistant must also have institutional practice privileges for each procedure requested and performed.

Applicant Signature

Date

Supervising Radiation Practitioner Signature

Date

Alternate Supervising Radiologist Signature

Date

Check this box if you use another page to list additional procedures or additional Alternate Supervising Radiologists.

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Approval Signature: _____ **Approved Date:** _____



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

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

Phone (501) 296-1802 www.armedicalboard.org

RADIOLOGIST ASSISTANT ALTERNATE SUPERVISING RADIOLOGIST APPLICATION

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

RADIOLOGIST ASSISTANT

Radiologist Assistant's Name

ALTERNATE SUPERVISING RADIOLOGIST INFORMATION

Alternate Supervising Radiologist's Name	Medical License Number
--	------------------------

Complete 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 _____

PRIMARY SUPERVISING RADIATION PRACTITIONER INFORMATION

Primary Supervising Radiation Practitioner	License Number
--	----------------

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

RADIOLOGIST ASSISTANTS CURRENTLY UNDER YOUR SUPERVISION

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

Continue to next page

IMPORTANT INFORMATION

THE FOLLOWING ITEMS MUST BE INCLUDED WHEN SUBMITTING THIS APPLICATION.

1. Signed Arkansas Medical Practices Act and Rules & Regulations Affidavit
2. Signed Alternate Supervising Radiologist Scope of Practice Statement
3. Signed Practice Specific Document

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

Supervising Radiation Practitioner's Signature
(does not require Notary)

Date Signed

Alternate Supervising Radiologist's Signature
(must be signed in the presence of a Notary Public)

Date Signed

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

this _____ day of _____, 20_____.

My commission expires: _____

Notary Signature

(Notary Seal)



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

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

Phone (501) 296-1802 www.armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

Alternate Supervising Radiologist

I AFFIRM THAT I HAVE READ THE RADIOLOGY ASSISTANT ACT, ARKANSAS CODE 17-106-201, et seq., MEDICAL PRACTICES ACT AND THE RULES AND REGULATIONS 29 OF THE ARKANSAS STATE MEDICAL BOARD.

I UNDERSTAND THAT I TAKE FULL RESPONSIBILITY FOR THE ACTIONS OF

_____ **WHILE HE/SHE IS UNDER MY SUPERVISION.**

Alternate Supervising Radiologist's Name (First Middle Last, Suffix, Degree)

Alternate Supervising Radiologist's Signature (no rubber stamps)

Signature Date

**THIS IS A REQUIREMENT FOR LICENSURE.
YOU MUST COMPLETE THIS FORM AND RETURN IT TO:**

**ARKANSAS STATE MEDICAL BOARD
ATTN: R.A. LICENSING COORDINATOR
1401 W. Capitol, Suite 340
LITTLE ROCK, AR 72201**



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

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ALTERNATE SUPERVISING RADIOLOGIST SCOPE OF PRACTICE STATEMENT

Regulation 29 states:

The Supervising Radiation Practitioner and Alternate Supervising Radiologist must have privileges to perform the procedure for which he/she is supervising the Radiologist Assistant. If an invasive procedure, the radiation practitioner must satisfy, at a minimum, the same educational and experience requirements as the Radiologist Assistant or Radiology Practitioner Assistant.

I have reviewed the Practice Specific Document of this Radiologist Assistant. My scope of practice and/or training is similar to the Supervising Radiation Practitioner and I feel that I can supervise this Radiologist Assistant in the absence of the Supervising Radiation Practitioner.

Alternate Supervising Radiologist's Full Name (First Middle Last, Suffix, Degree)

Alternate Supervising Radiologist's Signature (no rubber stamps)

Signature Date

Radiologist Assistant's Full Name

**THIS IS A REQUIREMENT FOR LICENSURE.
YOU MUST COMPLETE THIS FORM AND RETURN IT TO:**

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ATTN: R.A. LICENSING COORDINATOR
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LITTLE ROCK, AR 72201**



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Institution name and mailing address	
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VERIFICATION OF RADIOLOGIST ASSISTANT EDUCATION

PART I - APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number	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 signatures)	Date Signed (mm/dd/yyyy) / /	

FOLLOWING 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's Licensure Department at the address above. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

PART II - VERIFICATION

Name of Radiologist Assistant School/Program (if not correct above)		
Date R.A. Education Began / /	Date R.A. Education Ended / /	Degree Awarded <input type="checkbox"/> R.A. <input type="checkbox"/> Other _____ <input type="checkbox"/> Neither (did not complete)
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 III - VERIFIED BY

Verification provided by (Signature)	Signature Date / /
Type or legibly print name	
Position/Title	
Phone Number	Fax Number
Email Address	

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



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

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

Phone (501) 296-1802 www.armedicalboard.org

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

Licensing Authority's name and mailing address	
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VERIFICATION OF LICENSURE

PART I - APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number	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 signatures)		Date Signed (mm/dd/yyyy) / /

FOLLOWING 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's Licensure Department at the address above. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

PART II - VERIFICATION

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 radiologist assistant 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 radiologist assistant or the radiologist assistant'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 radiologist assistant'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 III - VERIFIED BY

Verification provided by (Signature)	Signature Date / /	
Type or legibly print name	Position/Title	
Phone Number	Fax Number	Email Address

**PLEASE RETURN THIS FORM DIRECTLY TO
THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR EMAIL.
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Documents submitted by email must be sent in PDF format to support@armedicalboard.org

Institution name and mailing address	
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VERIFICATION OF HOSPITAL/CLINIC RADIOLOGIST ASSISTANT (or RADIOLOGY PRACTITIONER ASSISTANT) AFFILIATION

PART I - APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number	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 signatures)	Date Signed (mm/dd/yyyy) / /	

FOLLOWING TO BE COMPLETED BY HOSPITAL OR CLINIC AUTHORIZED REPRESENTATIVE ONLY

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board's Licensure Department at the address above. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

PART II - VERIFICATION

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: If there are breaks between staff appointments, those appointments should be listed as separate entries. Please provide a separate sheet listing the start and end date of each period during which the radiologist assistant was continuously affiliated with your facility, or you may copy this form to report each period. Thank you.		
Specialties and/or Subspecialties in which clinical privileges were last held		Department
To the best of your knowledge, are/were the radiologist assistant'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 radiologist assistant ever denied, revoked, limited or suspended? (if Yes, please attach detailed explanation)		<input type="checkbox"/> Yes <input type="checkbox"/> No

PART III - VERIFIED BY

Verification provided by (Signature)		Signature Date
Type or legibly print name	Position/Title	
Phone Number	Fax Number	Email Address

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



ARKANSAS STATE MEDICAL BOARD

RADIOLOGIST ASSISTANT LICENSURE DEPARTMENT

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

Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org

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

Insurance Agency name and mailing address	
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VERIFICATION OF PROFESSIONAL LIABILITY INSURANCE

PART I - APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number	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 signatures)		Date Signed (mm/dd/yyyy) / /

FOLLOWING TO BE COMPLETED BY AUTHORIZED REPRESENTATIVE ONLY

Please complete the information below (or your equivalent verification letter) and return, **with a certificate copy**, to the Arkansas State Medical Board's Licensure Department by mail or fax. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

PART II - VERIFICATION

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 judgment 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 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 applicant.</i>			

PART III - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name	Position/Title	
Phone Number	Fax Number	Email Address

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



ARKANSAS STATE MEDICAL BOARD

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Phone (501) 296-1802 www.armedicalboard.org

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ACTIVE DUTY personnel, send this form to Commanding Officer at current duty station	
---	--

Inactive U.S. military personnel may provide proof of service by submitting a copy of his/her DD214.

VERIFICATION OF MILITARY SERVICE

PART I - APPLICANT INFORMATION

Full Name (Last, First, Middle, Rank)		Social Security Number		Date of Birth (mm/dd/yyyy) / /	
Country and Branch of Service	Date of Entry / /	Date of Separation / /	Current Status (Active, Inactive, etc.)		
<i>AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all military records and 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 signatures)				Date Signed (mm/dd/yyyy) / /	

FOLLOWING TO BE COMPLETED BY AUTHORIZED PERSONNEL ONLY

Please complete the information below (or your equivalent verification letter) and return the original documents directly to the Arkansas State Medical Board's Licensure Department at the address above. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

PART II - VERIFICATION

Branch of Service	Date of Entry (mm/dd/yyyy) / /	Date of Separation (mm/dd/yyyy) / /	Current Status (Active, Inactive, etc.)
PLEASE PROVIDE THE FOLLOWING DOCUMENTS/RECORDS			
<ul style="list-style-type: none"> ▪ Records of Radiologist Assistant training in the military ▪ Records of military hospital privileges ▪ Records of any disciplinary problems; alcohol or substance abuse problems; or mental or emotional impairments 			

PART III - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name	Position/Title	
Phone Number	Fax Number	Email Address

**PLEASE RETURN THIS FORM DIRECTLY TO
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CHANGE TO PRACTICE SPECIFIC DOCUMENT (ALTERNATE SUPERVISING RADIOLOGIST)

The Practice Specific Document that is being submitted has not changed from my last approval by the ASMB Radiologist Assistant Advisory Committee with the exception of changing my Alternate Supervising Radiologist.

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

Radiologist Assistant's Signature (no rubber stamps)

Signature Date

Name of Alternate Supervising Radiologist

**THIS IS A REQUIREMENT FOR APPROVAL WHEN ADDING OR CHANGING
AN ALTERNATE SUPERVISING RADIOLOGIST.**

YOU MUST COMPLETE THIS FORM AND RETURN IT TO:

**ARKANSAS STATE MEDICAL BOARD
ATTN: R.A. LICENSING COORDINATOR
1401 W. Capitol, Suite 340
LITTLE ROCK, AR 72201**

ARKANSAS STATE MEDICAL BOARD



ARKANSAS MEDICAL PRACTICES ACTS & REGULATIONS FOR RADIOLOGIST ASSISTANTS

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RADIOLOGIST ASSISTANTS AND RADIOLOGY PRACTITIONER ASSISTANTS

17-106-201. Radiologist assistant and radiology practitioner assistant – License required.

- (a) The Arkansas State Medical Board shall grant a license to practice as a radiologist assistant and a radiology practitioner assistant to a qualified applicant who complies with the rules for licensure adopted under this subchapter.
- (b) An individual shall not practice as a radiologist assistant or a radiology practitioner assistant unless the person is licensed as a radiologist assistant or a radiology practitioner assistant by the board.

17-106-202. Rules. The Arkansas State Medical Board shall adopt rules to:

- (1) Define the qualifications for licensure of a radiologist assistant or a radiology practitioner assistant;
- (2) (A) Define the services that may be performed by a radiologist assistant or a radiology practitioner assistant, and the level of supervision required for the performance of a radiologist assistant or a radiology practitioner assistant.
(A) The rules adopted under subdivision (2)(A) of this section shall specify that a radiologist assistant or radiology practitioner assistant shall not interpret images, make diagnoses, or prescribe medications or therapies;
- (3) (A) Define the qualifications of a supervising physician.
(B) The rules adopted under subdivision (3)(A) of this section shall specify the manner and scope of supervision that a licensed physician must employ when supervising a radiologist assistant or a radiology practitioner;
(C) (i) Only a physician licensed to practice medicine in the State of Arkansas under 17-95-401, et seq. who resides in Arkansas or in an immediately contiguous county of an adjacent state and who is a diagnostic radiologist certified by or eligible for certification by the American Board of Radiology or an equivalent board approved by the Arkansas State Medical Board may utilize the services of a radiologist assistant or a radiology practitioner assistant.
(ii) However, a physician may utilize the services of a radiologist assistant or a radiology practitioner assistant under subdivision (3)(C)(i) of this section only if the physician supervises the radiologist assistant or radiology practitioner assistant;
- (4) Establish requirements for annual renewal of the license of a radiologist assistant and a radiology practitioner assistant;
- (5) Establish continuing education requirements for renewal of licensure for a radiologist assistant and a radiology practitioner assistant; and
- (6) Establish a program for probation of a radiologist assistant and a radiology practitioner assistant.

17-106-203. Fee. The Arkansas State Medical Board shall charge a licensure application fee not to exceed the administrative and disciplinary costs incurred by the board in administering the licensure program under this subchapter.

17-106-204. Penalties. If a radiologist assistant or a radiology practitioner assistant is found by the Arkansas State Medical Board to have violated the Arkansas Medical Practices Act, 17-95-201 et seq., or the rules adopted under this subchapter, the board may impose one (1) or more of the following penalties:

- (1) Suspension or revocation of the license to practice as a radiologist assistant or radiology practitioner assistant;
- (2) A fine not to exceed one thousand dollars (\$1,000) per violation;
- (3) Recovery from the radiologist assistant or the radiology practitioner assistant of the costs of an investigation and hearing if the radiologist assistant or the radiology practitioner assistant is found to have violated the Arkansas Medical Practices Act, 17-95-201 et seq., or the rules adopted under this subchapter;
- (4) Placement of the radiologist assistant or the radiology practitioner assistant under probation; and
- (5) A reprimand.

History. Acts 2009, No. 1457 § 2.

REGULATION 29 GOVERNING RADIOLOGY ASSISTANTS/RADIOLOGY PRACTITIONER ASSISTANTS

I. DEFINITIONS

- A. Licensed Practitioner means a person licensed to practice medicine, dentistry, podiatry, chiropractic, osteopathic, or optometry in the State of Arkansas;
- B. Radiation Practitioner means a licensed practitioner who has completed a residency in radiology, nuclear medicine, or radiation oncology, AND is certified by the American Board of Radiology, the American Osteopathic Board of Radiology, or the American Board of Nuclear Medicine or its equivalent;
- C. Radiologist Assistant (RA) or Radiology Practitioner Assistant (RPA) a person other than a licensed practitioner, who has specific qualifications, education, certification and responsibilities as recognized by the Arkansas State Medical Board and who has been issued a license to perform certain functions under the supervision of Licensed Radiation Practitioner;
- D. Supervising Radiation Practitioner means a radiation practitioner using the services of RA or RPA and is responsible for the professional activities and services of the RA or RPA under these Rules and Regulations;
- E. Alternate Supervising Radiologist means a radiation practitioner other than the supervising radiologist who is responsible for the supervision of RA or RPA for specific procedures in accordance with all Rules and Regulations applicable to the supervising radiation practitioner;
- F. Personal Supervision means the supervising and/or alternate supervising radiation practitioner must be in attendance in the room with the RA or RPA during the performance of the procedure or task;
- G. Direct Supervision means the supervising and/or alternate supervising radiation practitioner and/or radiologist must be present in the facility and immediately available to furnish assistance and direction to the RA or RPA during the performance of

the procedure or task. The radiation practitioner is not required to be present in the room during the performance of the procedure or task;

- H. General Supervision means the procedure is furnished under the supervising and/or alternate supervising radiation practitioner's overall direction and control, but the practitioner is not required to be in the same room or facility with the RA or RPA during the performance of the procedure or task;

II. REQUIREMENTS

The Radiologist Assistant (RA) and the Radiology Practitioner Assistant (RPA) must obtain a permit from the Arkansas State Medical Board to practice in the State of Arkansas, in order to obtain said permit the RA or RPA must comply with the following:

- A. Complete and submit an application and provide such information as the Board requires.
- B. Provide proof of successfully passing the Registered Radiologist Assistant examination by the American Registry of Radiologic Technologists, or provide proof of licensure in Arkansas by 2007 as a RA or RPA through the Division of Ionizing Radiation at the Arkansas State Department of Health.
- C. Be at least 18 years of age.
- D. Provide the names and signatures of the supervising and alternate supervising radiation practitioners licensed to practice in the State of Arkansas who agree to supervision of the RA or RPA under the terms of these Rules and Regulations.
- E. Provide a practice-specific document delineating the specific procedures and tasks to be performed by the RA or RPA in each facility utilized, including the level of supervision to be provided by the supervising licensed radiation practitioners.
- F. Pay a licensure fee of \$75.00 to the Board with the application for the initial permit. The supervising and alternate supervising radiation practitioners must sign the application form that they have read the Rules and Regulations and will abide by same, including disciplinary actions pertaining to the RA or RPA and themselves.
- G. Pay a renewal fee of \$50.00 with the annual renewal form for a permit and a copy of the practice privileges for each facility where the procedures are performed. The supervising and alternate supervising radiation practitioners must sign the renewal form that they have read the Rules and Regulations and will abide by same, including disciplinary actions pertaining to the RA or RPA and themselves.
- H. A request must be submitted for Board approval of any changes in supervising or alternate supervising radiation practitioners, and for any changes to the practice-specific document delineating the specific procedures and tasks to be performed by the RA or RPA in each facility utilized, including the level of supervision to be provided by the supervising licensed radiation practitioner(s).

III. ROLES AND RESPONSIBILITIES

The RA or RPA may perform the tasks and functions as approved by the Board AND for which practice privileges have been secured at each facility where the procedure is performed.

Prescriptive authority for medications and images interpretation are expressly prohibited. Initial observation of the images by the RA and RPA may be communicated only to the supervising radiation practitioner. The RA and RPA may communicate the radiologist's interpretation to other care providers.

IV. THE PRACTICE-SPECIFIC DOCUMENT

The practice-specific document is to be completed and signed by the RA or RPA and the supervising licensed radiation practitioner supervisor. The practice-specific document must be accepted and approved by the Arkansas State Medical Board prior to the licensure of the RA or RPA. Any change in the practice-specific document shall include the following:

- A. Procedures or tasks to be performed by the RA or RPA with the level of supervision to be provided by the licensed practitioner(s). All invasive procedures listed require a minimum level of direct supervision.
- B. Name and address of facility where the procedure(s) will be performed.
- C. The name of the alternate supervising licensed radiation practitioner(s).

V. SUPERVISION

The radiation practitioners assume full responsibility for the actions of the RA and RPA. If there is any uncertainty regarding supervision of the RA and RPA, the designated supervising radiation practitioner has ultimate responsibility.

Supervising and alternate supervising radiation practitioners must have the privileges to perform the procedures for which he/she is supervising for the RA and RPA. If it is an invasive procedure, the radiation practitioners must satisfy, at a minimum, the same educational and experience requirements as the RA or RPA.

All invasive procedures require a minimum level of direct supervision, and conscious sedation requires personal supervision by the radiation practitioner.

VI. DISCIPLINARY ACTION

An RA and RPA must comply with the Medical Practices Act and the Rules and Regulations of the Board. Should the Board find that there is probable cause that in RA or RPA has not complied with the Medical Practices Act and the Rules and Regulations of the Board, the Board will bring charges alleging the wrongful conduct and said disciplinary proceeding will comply with the Administrative Procedure Act of the State of Arkansas. At the conclusion of the disciplinary hearing, if the Board finds that the RA or RPA has violated the medical Practices Act or the Rules and Regulations of the Board, the Board may impose one or more of the following sanctions:

- A. Revoke the permit to practice in Arkansas as a RA or RPA.
- B. Suspend the permit for a period of time as determined by the Board.
- C. Issue a reprimand.

- D. Supervising radiation practitioners may be subject to disciplinary action by the Board if the RA or RPA violates the Medical Practices Act or the Rules and Regulations.

VII. CONTINUING MEDICAL EDUCATION

- A. An RA or RPA with an active permit to practice in the State of Arkansas shall complete 6 credit hours per year of continuing medical education acceptable to the American Registry of Radiologic Technologists and/or the American Medical Association.
- B. If a person holding an active permit as an RA or RPA in this State fails to meet the foregoing requirement because of illness, military service, medical or religious missionary activity, residence in a foreign country, or other extenuating circumstances, the Board upon appropriate written application may grant an extension of time to complete the same on an individual basis.
- C. Each year with the application for renewal of an active permit as an RA or RPA in this state, the Board will include a form which requires the person holding the permit to certify by signature under penalty of perjury, and discipline by the Board, that he or she has met the stipulating continuing medical education requirements. In addition, the Board may randomly require the RA or RPA submitting such certification to demonstrate, prior to renewal of the permit, satisfaction of continuing medical education requirements stated in his or her certification.
- D. Continuing medical education records must be kept by the permit holder in an orderly manner. All records relative to continuing medical education must be maintained by the licensee for at least 3 years from the end of the reporting period. The records or copies of the forms must be provided or made available to the Arkansas State Medical Board upon request.
- E. Failure to complete continuing education hours as required, or failure to be able to produce records reflecting that one has completed the required minimal medical education hours shall be a violation and may result in the permit holder having his permit suspended and/or revoked.

History: Adopted: February 7, 2008