ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 www.armedicalboard.org

TELEMEDICINE AFFIDAVIT

I, _____, hereby certify, after being duly sworn, that I have read A.C.A. §17-80-118 and Arkansas State Medical Board Regulations No. 2(8) and No. 38, and know the full content thereof. I declare, under penalty of perjury, that I will comply with the requirements set forth in this statute and regulation, and I understand and agree that failure to do so is sufficient grounds for denying, revoking, suspending, or otherwise disciplining a license or permit to practice medicine in the State of Arkansas.

_____
Physician's Full Name (First Middle Last, Suffix, Degree)
(Must be signed in the presence of a Notary Public)

_____
Physician's Signature (no rubber stamps)

_____
Signature Date

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

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