



ARKANSAS STATE MEDICAL BOARD

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

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

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

APPLICATION FOR PRE-APPROVAL OF RESPIRATORY THERAPY CONTINUING EDUCATION PROGRAM

1. Type or print legibly (in dark blue or black ink).
2. All questions must be answered. Please do not write "see attached" as sections must be completed even if you are attaching documentation.
3. Completed application and documentation must be submitted to our office no later than one week prior to the program start date.

Sponsor Agency/Institution		
Contact Person		
Mailing Address		Suite
City	State	Zip Code
Phone Number	Fax Number	E-mail Address
Program Dates: Starting:	Ending:	Program Name:
Location Address (if different than address above)		
City	State	Zip Code
Total Number of CEU's requested: (Count only instructional time. Do not include registration, breaks, practicing or testing time.)		
Can participants receive credit for partial attendance? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe how partial attendance will be verified and granted:		
Target Audience (Check all that apply): Clinician <input type="checkbox"/> Manager/Supervisor <input type="checkbox"/> Educator <input type="checkbox"/> Nurse <input type="checkbox"/> Physician <input type="checkbox"/>		
Teaching methods (Check all that apply): Lecture <input type="checkbox"/> Textbook <input type="checkbox"/> Workshop <input type="checkbox"/> Clinical <input type="checkbox"/> Collaborating <input type="checkbox"/>		
Reading Journals/Articles <input type="checkbox"/> Panel Discussion <input type="checkbox"/> Charts <input type="checkbox"/> Photographs <input type="checkbox"/> Brainstorming <input type="checkbox"/> Webcast <input type="checkbox"/>		
Mock Presentation <input type="checkbox"/> Evidence-Based Case Studies <input type="checkbox"/> Webinar <input type="checkbox"/> Self-Study <input type="checkbox"/> Other: <input type="checkbox"/> _____		
Name of Speaker(s)		
Learning Objectives		

PLEASE RETURN THIS FORM, COPY OF BROCHURE/AGENDA, EVALUATION FORM, AND APPLICABLE DOCUMENTATION DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org)