ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 West Capitol, Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@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 and each of its components are available on our web site, www.armedicalboard.org. If you received this packet from a source other than directly from the Arkansas State Medical Board or its official website, the application may be outdated or not an official version. Please be advised that outdated or unofficial versions of the application will not be accepted.

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

ABANDONED APPLICATIONS. Applications which are not complete after twelve (12) months will be classified as Abandoned and will be removed from our system. Further, pending applications will be listed as abandoned if the applicant does not communicate with the Board office for six (6) months. Abandoned files will be maintained for 30 days and then destroyed. No refunds will be given on abandoned/inactive applications.

APPLICATION FEES. The fee for full licensure is **$4** (four) and must be included with your application at the time of submission. Payment may be made by check or money order payable to *Arkansas State Medical Board*. **Do not send cash.**

APPLICATION REVIEW. The application review process is defined by the requirements set forth in state law. The board and its staff must comply with those laws in processing applications. Applications are processed in the order in which they are received in our office and in the order verifications are obtained. THE BOARD DOES NOT ACCELERATE ONE APPLICANT OVER ANOTHER.

ARKANSAS MEDICAL PRACTICES ACTS AND RULES. The Radiology Assistant Act (A.C.A. § 17-106-201 et seq.) and Rules 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 Medical Practices Act and Rules Affidavit located in this packet. Applications received without this form will be returned. The Radiology Assistant Act and the Regulations are part of the Arkansas Medical Practices Act which can be viewed and downloaded from our web site, www.armedicalboard.org.

CHANGE OF ADDRESS. Rule 33 requires you to notify the Arkansas State Medical Board of any changes to your address within 30 days of such change. This includes your relocation to Arkansas, if applicable. A change of address form is available for download at our website, www.armedicalboard.org. Any address change MUST BE IN WRITING. The form must be fully completed, signed and dated. Once you are licensed, you may change your address online.

CHECKING THE STATUS OF YOUR APPLICATION. The Arkansas State Medical Board's required form of communication is an interactive Applicant Portal system which allows communication between the Board and the applicant via the web. We have found that this system is a very effective communication tool and significantly reduces the time to licensure once your access identification has been assigned. You may access the Applicant Portal system from any computer at any time by visiting the Medical Board's web site at: http://www.armedicalboard.org.

When using the system, you will see a status bar which will show the percentage completed of your application process. Additional information regarding items that need your attention will be provided to you via a "Click here to respond" link on the "Applicant Portal Home" page. You will need to access your open items by choosing this link and providing a response to the items for which a response is requested.

This interactive system allows the licensing coordinator the time necessary to work your file as opposed to responding to numerous phone calls or e-mails from various interested parties checking on the status of your application. It also allows you to review the progress of your application at any time. You may 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.

COMMITTEE APPEARANCE. Applicants and supervising radiation practitioners may be required to appear before the ASMB Radiologist Assistant Advisory Committee for licensure. The determination will be based on individual review of the submitted application. ASMB Radiologist Assistant Advisory Committee meeting dates may change at the discretion of the Committee or the Arkansas State Medical Board. Meeting dates will be provided to you by your Licensing Coordinator.

COMPLETING THE APPLICATION. READ THE INSTRUCTIONS FOR EACH QUESTION BEFORE ANSWERING. The application may NOT be submitted electronically, 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. Pages must be printed on one side only. Two sided (front and back) applications will cause delays due to pages needing to be resubmitted.

CRIMINAL BACKGROUND CHECK. Act 1249 of 2005 authorizes the Arkansas State Medical Board to conduct criminal background checks (both state and federal) on ALL applicants for licensure.
Arkansas Code 17-95-306 states:

(a) (1) Beginning July 1, 2005, every person applying for a license or renewal of a license issued by the Arkansas State Medical Board shall provide written authorization to the board to allow the Arkansas State Police to release the results of a state and federal criminal history background check report to the Board.

(2) The applicant shall be responsible for payment of the fees associated with the background checks.

If you live outside of Arkansas:
Upon receipt in this office of your completed application and fee, a CBC packet, including forms and instructions, will be mailed to your private address for completion. You need to complete and return these forms at your earliest convenience as the Federal portion of this background check can take several weeks or more to process. ASMB will NOT accept a previously obtained criminal background check, regardless of how recently it was performed or what organization provides it. Payment for the CBC must be made by money order. Complete instructions will be provided in the CBC packet. It is vital that the completed CBC packet be returned to the Board in a timely manner as failure to do so will delay licensure.

If you live in Arkansas:
Upon receipt in this office of your completed application and fee, an email will be sent to you from Support@armedicalboard.org regarding the necessary steps to be fingerprinted so your criminal background

check can be conducted. It is vital that you follow these instructions as soon as possible to avoid delay in the licensing process.

Act 630 of 2021 was enacted which amended A.C.A. 12-12-1005. Beginning September 1, 2021, paper fingerprint cards (FD-258) are no longer being accepted by the Arkansas State Police for Arkansas residents and requires that background checks must be submitted by electronic means only:

(d)(1)A background check request for a non-criminal justice purpose that must be completed under state or federal law through the Division of Arkansas State Police shall be submitted to the division by electronic means through the Arkansas State Police Criminal Background Check System.
(2) This subsection does not apply to a submission originating outside the State of Arkansas.

Any licensing applicant living within the state of Arkansas will be required to submit their fingerprints electronically via Arkansas LiveScan. Do not do this step until you have received an acknowledgement email from this office. Failure to do so will result in an unsuccessful transmission of your fingerprints.

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 e-mail 60 days prior to the end of your birth month. A follow-up e-mail will be sent at approximately 45 days and a final e-mail 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.**

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 and in the order verification documents are provided. The Board does NOT accelerate one applicant over another.

SUBMITTING THE APPLICATION. The application may NOT be submitted electronically, as we do require your original signature on the hard copy and all fees to be paid at submission.

TIME GAPS. Any time gaps of 30 days or more must be explained in writing. You will be notified of any unexplained time gaps and asked to provide an explanation. To avoid processing delays, please include a separate signed explanation of any time gaps of 30 days or more with your original application. Failure to address time gaps may result in delay of licensure.

U.S. POSTAL SERVICE. If you choose to utilize the U.S. Postal Service, please be advised that they do NOT guarantee delivery of first class mail, and they do NOT guarantee delivery of Certified mail. Based on the lengthy delays we have experienced in receiving mail 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.

VERIFICATIONS. It is the policy of this Board that ALL education, training, and professional affiliations and other activities since graduation from Radiologist Assistant School (or within the past 5 years whichever is less) be verified by the primary source prior to issuance of a permanent license. It is the applicant's responsibility to request verifications and to follow up with organizations to ensure verifications are provided to the Board. Applicants are required to sign verification documents where indicated in Part II prior to sending to the verification source. The verifier's signature can be original, stamped or computer-generated. All verifications will be accepted via fax or e-mail unless specifically requested to be mailed. To fax, send to (501) 296-1972, Attn: Licensing. To e-mail, the document must be attached as an Adobe PDF file and sent to

support@armedicalboard.org with “Attn: Licensing” in the subject line. Note that if the attachments are not sent in this format and to this address, they will be stripped by the firewall and will not be received by the intended recipient.

WITHDRAWN APPLICATIONS. Applications which are withdrawn by the applicant will be maintained for 30 days and then destroyed. No refunds are given on applications that are withdrawn.

“YES” RESPONSES. A “Yes” response in the attestation portion of the application does not mean your application will be denied. If you have responded “Yes” to any of these questions, additional time will be required for the gathering and assessment of pertinent information. You will be required to provide a separate, signed and complete explanation for each “Yes” response; you can expedite this process by including these with your original application. Failure to appropriately answer questions may result in an appearance before the Board for full licensure; disciplinary action; and/or denial of a license.

RADIOLOGIST ASSISTANT REQUIREMENTS FOR MEDICAL LICENSURE IN ARKANSAS

LICENSURE REQUIREMENTS:

(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 Technologists, 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 $4 (four) 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 Medical Practices Act and Rules and will abide by same, including disciplinary actions pertaining to the RA or RPA and themselves.
(7) Must complete a background check.
(8) Must present indisputable identification.

LICENSURE IS BY CREDENTIALS:

- Credentials must be verified from the originating source.

LICENSING EXAMINATION MEETING THE BOARD REQUIREMENTS IS AS FOLLOWS:

- Registered Radiologist Assistant (RRA) Examination

LICENSE APPLICATION CHECKLIST

(Use this checklist to be sure your application is complete prior to sending to the Arkansas State Medical Board)

USE THE FOLLOWING ADDRESS FOR ALL DOCUMENT SUBMISSION:

ARKANSAS STATE MEDICAL BOARD
ATTN: LICENSING DEPARTMENT
1401 WEST CAPITOL AVE., STE. 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 $4 (four)
- ☐ Application (5 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. Do not complete the application on front and back pages. Use one sided pages only.
- ☐ Signed and dated explanations for any time gaps of 30 days or more since the end of radiologist assistant education
- ☐ 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 if desired (form in packet)
- ☐ CBC Privacy Right Statement
- ☐ 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 completing your RA/RPA education.

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.arrt.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)
  Board staff will obtain these for you online. However, in the event a state does not offer the license verification online, if there is a fee, or the website has not been updated, the applicant will be responsible for requesting and

paying any fees. The ASMB must have verification of all licenses ever held, even temporary licenses, whether active or inactive.

- ❑ **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 a claims history report. For any pending cases, an attorney narrative of the case is required in addition to the applicant's signed narrative.

- ❑ **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.

- ❑ **Physicians Health Committee Documents**
  If you are now being or have ever been monitored by a Physician Health Committee in any state or country, ask the director of that program to furnish a copy of your contract and a letter verifying your status. If you are currently under a PHC contract, you must also contact the Arkansas Physicians' Health Committee:

  Arkansas Physicians' Health Committee
  Arkansas Medical Foundation
  10 Corporate Hill, Suite 150
  Little Rock, AR 72205
  (501) 224-9911

INSTRUCTIONS FOR COMPLETING LICENSURE APPLICATION

1. READ ALL INSTRUCTIONS.
2. Type or print legibly in dark blue or black ink all application documents. (One sided documents only.)
3. Provide exact dates (mm/dd/yyyy) whenever possible.
4. ANSWER ALL QUESTIONS/SECTIONS, even if your answer is "n/a," "Not Applicable," "None," or "Pending."
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 attach 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.
8. All signatures must be the applicant's; stamped signatures, signatures by proxy, and signatures by power of attorney are NOT accepted.

Indicate if you are a current or former member of the United States military or are the spouse of a current or former member of the United States military.

Question 1: Your Name

a. 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.
b. Enter any other names used during your education or career, such as maiden name, nicknames, etc.

Question 2: Your Identification

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

Question 3: Birthplace/Citizenship

a. Enter the city and state (or city and country) where you were born.
b. 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.*
c. 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".
d. 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".
e. Indicate your ethnicity by checking the appropriate box.
f. Indicate your race by checking the appropriate box.

Question 4: Your Contact Information (Both addresses must be completed even if they are the same)

a. Enter your Public mailing address. **This field is required.** This address appears on all printed reports, bulk data listings, the Online Directory and the free, online license verification system. It is also available to the general public under Freedom of Information (FOI), and all other reports available to the credentialing organizations utilizing the ASMB website for license and/or credentials verification.
b. Enter your Private mailing address. **This field is required.** The Private address is used to send renewal reminders, direct and confidential communication from the Board and the Board's quarterly Newsletter. It is NOT available to the public under FOI ***unless*** you also use this address as your public address.
c-f. Enter your private, work, fax, and mobile phone numbers in the appropriate spaces.
g. Enter your personal e-mail address. **Your personal e-mail address is required.** This is the e-mail address through which you will receive automated system messages as to the status of your application. You may also receive private and confidential e-mails for clarification purposes from the licensing staff. This is NOT your primary contact's e-mail address, as this e-mail address will carry over towards the required online renewal setup.

Question 5: Intended Practice Location

a. Enter the name of the hospital, clinic, group or private practice where you will be practicing in Arkansas.
b. Enter the mailing address of the hospital, clinic, group or private practice where you will be practicing.
c. 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."
d. 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."*
e. Enter the name of the physician that will be your Alternate Supervising Radiologist.
f. Enter your Alternate Supervising Radiologist's specialty.

Question 6: Education

a. 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.*

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

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 sent directly to this office. If you have not taken and passed the exam, send a copy of your verification to sit for the next exam.*

Question 8: Licenses

a. 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.
b. Enter your RA or RPA license number.
c. 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, you must have your current Commanding Officer submit a verification letter directly to this office OR complete Parts I and II of the "Verification of Current Military Service" form and send it to the appropriate department in the United States military for them to complete and return to this office. Verifications must be returned from the source to this office.*
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 your employer. You must list all professional activities since graduation from Radiologist Assistant school 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 for the past five years or since graduating from radiologist assistant school, whichever is shorter. 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 and indicate the facility is closed.*
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.

QUESTIONS 11-19 (ATTESTATION QUESTIONS):

For each "YES" response to questions 11 through 19, 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. If, during the application process, you become aware of any investigation, action, or other circumstance relating to questions asked in this section, you are required to report it to this office.

FOR QUESTION 11:

If you answer yes to this question, in addition to the written explanation outlined above, you must also attach a copy of charging document, 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, <u>you are still required to answer "Yes" to this question and provide documentation.</u>**

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 under the photograph. The signature date and notary date must match. *Applications received without a photo or the required Notary seal will be returned to the applicant for completion, thereby delaying the application process.*

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol, Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org

Are you a current or former member of the U.S. military or a spouse of a current or former member of the U.S. military? ☐ Yes ☐ No

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. (one sided only)
3. Provide exact dates whenever possible, in *mm/dd/yyyy* format.
4. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.
5. Give careful thought to each question before answering; remember, you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in 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 ☐ Male ☐ Female	2d. Date of Birth (mm/dd/yyyy) / /
3a. Place of Birth (City and State/Country)		3b. Country of Citizenship	
3c. Immigration Status (if not U.S. citizen)		3d. How long have you been in the U.S.? (if not U.S. citizen)	
3e. Ethnicity ☐ Non-Hispanic ☐ Hispanic		3f. Race ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Black/African American ☐ White ☐ Hawaiian/Pacific Islander	
4a. Public Address (Street, City, State, Zip Code)			
4b. Private Address (Street, City, State, Zip Code)			
4c. Private Phone #	4d. Work Phone #	4e. Fax #	4f. Mobile Phone #
4g. Personal E-mail Address			
5a. Intended Practice Location in Arkansas: Full Name Hospital, Clinic, Group or Private Practice			
5b. Mailing Address of Intended Practice Location (PO Box or Street, City, State, Zip Code)			
5c. Name of Supervising Radiation Practitioner		5d. Supervising Radiation Practitioner's Specialty	
5e. Name of Alternate Supervising Radiologist		5f. Alternate Supervising Radiologist's Specialty	

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Application Received: / /	Fee Received: $
RA License #:	Full License Issued: / /

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 submit Verification of Radiologist Assistant Education form and official transcript 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 HISTORY

7. 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 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 (DD Form 214) with your application. If Active Duty, have the Verification of Current Military Service sent to this office or have your current Commanding Officer submit a verification letter directly to this office.

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. If you need more space, additional sheets may be attached.**

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

continue to next page

PART IV - ATTESTATION QUESTIONS

SPECIAL INSTRUCTIONS FOR QUESTIONS 11-19

- Please mark the appropriate box next to each question. Do not leave any questions blank.
- For each "Yes" response to questions 11-19, 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.

11.	Since the age of 18, have you been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony (including DWI (Driving While Intoxicated) or DUI (Driving Under the Influence)? (NOTE: **You must answer "Yes" even if records, charges, or convictions have been pardoned, expunged, plead down, released, or sealed**.) If yes, explain.	☐ No ☐ Yes
12.	Do you have any physical, mental or emotional impairment that has the potential to hinder your ability to perform duties assigned in any healthcare profession including that of Radiology Assistant? *If yes, explain.*	☐ No ☐ Yes
13.	Since the age of 21, have you been, or are you currently, being treated for alcoholism or substance abuse in an inpatient or outpatient setting? If yes, explain.	☐ No ☐ Yes
14.	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
15.	Have you ever been ordered to appear before a state licensing board for any reason other than licensure? *If yes, explain.*	☐ No ☐ Yes
16.	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
17.	Have you ever voluntarily surrendered your license in any other state? *If yes, give name and address of board in your explanation.*	☐ No ☐ Yes
18.	Have any malpractice claims been filed against you? *If yes, provide official documentation from your attorney or insurance company.*	☐ No ☐ Yes
19.	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, the undersigned applicant, after being duly sworn, hereby certify 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 be placed below the photograph at left)

ARKANSAS STATE MEDICAL BOARD

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

ARKANSAS MEDICAL PRACTICES ACT and RULES AFFIDAVIT

Radiologist Assistant

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE ANNOTATED § 17-106-201, *et seq.*, AND RULE 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

LICENSURE DEPARTMENT
1401 West 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@armedicalboad.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

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@armedicalboad.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 applicants at any given time, and that repeated phone calls to check on the status of your application will only delay the processing time for all applicants. We appreciate your consideration of this.

- This form is optional. If you do not choose to list a secondary contact designation, this form is not required.

I authorize the Arkansas State Medical Board to release any and all information regarding the status of my licensure application to the person listed below:

_____
Print full name of Secondary Contact

_____
Organization Name

_____
E-mail address of Secondary Contact

_____
Phone number of Secondary Contact

_____
Print full name of Applicant

_____
Signature of Applicant (no signature stamps)

_____
Date Signed

If you desire to utilize a secondary contact, this document must be completed and returned with your initial application. Information regarding your licensure application will not be released to anyone other than you without this written authorization. If you choose to utilize a designated contact, that person will be copied on all correspondence sent from this office regarding your application.

ARKANSAS STATE MEDICAL BOARD

1401 West Capitol, Suite 340 ● Little Rock, AR 72201 ● (501) 296-1802 ● Fax (501) 296-1972
www.armedicalboard.org ● Support@armedicalboard.org
Email attachments must be in PDF format

THIS NOTIFICATION SHOULD BE DETACHED AND RETAINED BY APPLICANT

FINGERPRINTS SUBMITTED WITH THIS APPLICATION WILL BE USED TO CHECK FBI CRIMINAL RECORDS

NOTIFICATIONS FORM

To obtain a Copy of your FBI Criminal Record:
Procedures for obtaining a copy of FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.30 through 16.33 or go to the FBI website at http://www.fbi.gov/about-us/cjis/background-checks

Changes, Corrections, or Updating of Federal Criminal Record:
Procedures for obtaining a change, correction, or updating of an FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34 or go to the FBI website at http://www.fbi.gov/about-us/cjis/background-checks

If, after viewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wish changes, corrections, or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Service (CJIS) Division, and ATTN: SCU, Mod. D2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting the agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency

Appeal of Determination:
If your determination is based on an error such as wrong person, birth date, etc., please contact Health Facility Services Criminal History determination section at 501-661-2201. You may appeal a determination error within sixty (60) days by submitting a written request to: Health Facility Services Criminal History Appeals, 5800 W. 10th Street, #400, Little Rock AR 72204. Include your contact information and a description of the error.

Arkansas Code §A.C.A. 20-38-101

PRIVACY RIGHT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

APPLICANT TO REVIEW AND SIGN

- I HEREBY GIVE MY CONSENT FOR THE ARKANSAS STATE POLICE AND THE FBI TO CONDUCT THE REQUIRED CRIMINAL RECORD CHECK ON MYSELF AND RELEASE ANY RESULTS TO THE LICENSING AUTHORITY AND THE STATE RESULTS TO THE QUALIFIED ENTITY
- I RECEIVED WRITTEN DIRECTIONS FOR CHANGES/CORRECTING/UPDATING MY FBI CRIMINAL RECORD
- I RECEIVED WRITTEN DIRECTIONS ON HOW TO OBTAIN A COPY OF MY FBI CRIMINAL RECORD
- I RECEIVED WRITTEN DIRECTIONS ALONG WITH THE TIME FRAME EXPLAINING HOW TO APPEAL THE ACCURACY/DISPOSITION INFORMATION

STATEMENT OF OATH:

I STATE ON OATH THAT THE REPRESENTATIONS MADE HEREIN ARE TRUE AND CORRECT.

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

Printed name of applicant *Signature of applicant* *Date*

Arkansas State Medical Board
1401 West Capitol, Suite 340
Little Rock, AR 72201
Phone: (501) 296-1802
Fax: (501) 296-1972
www.armedicalboard.org

Arkansas State Medical Board – Fee Waiver Form

17-5-104. Fee waiver. [Effective January 1, 2022.]

(a) Notwithstanding any law to the contrary, a licensing entity shall not require an initial fee for individuals who are seeking to receive a license in this state if the applicant:

(1) Is receiving assistance through the Arkansas Medicaid Program, the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, the Temporary Assistance for Needy Families Program, or the Lifeline Assistance Program;

(2) Was approved for unemployment within the last twelve (12) months; or

(3) Has an income that does not exceed two hundred percent (200%) of the federal poverty income guidelines.

(b) The waiver of the initial fee does not include fees for:

(1) A criminal background check;

(2) An examination or a test; or

(3) A medical or drug test.

In accordance with Ark. Code Ann. § 17-5-104, the Arkansas State Medical Board will waive the initial application fee providing the following conditions are met:

Fee Waiver Eligibility
Check all that apply:

- ☐ Arkansas Medicaid Program
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC)
- ☐ Temporary Assistance for Needy Families Program (TANF)
- ☐ Lifeline Assistance Program
- ☐ Have been approved for unemployment within the last twelve (12) months
- ☐ Have an income that does not exceed two hundred percent (200%) of the federal poverty income guidelines

Proof of eligibility* for the fee waiver and this signed form must accompany the application at the time of submission.

_____ _____

Applicant Signature Applicant Printed Name

*Documentation must include:

- Official documentation from the agency providing the benefits that you are receiving that includes your approval for benefit assistance
- Copy of your most recent tax return to show proof of having income that does not exceed 200% of the federal poverty income guidelines

ARKANSAS STATE MEDICAL BOARD

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.

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.

RADIOLOGIST ASSISTANT

Radiologist Assistant's Name

SUPERVISING RADIATION PRACTITIONER INFORMATION

Supervising Radiation Practitioner Name			AR License Number
Complete Address (PO Box or Street, City, State, Zip Code)			
Office Telephone Number	Office Fax Number	Home Telephone Number	Mobile Telephone Number
E-mail Address		Specialty	Board Certified? ☐ Yes ☐ No

Type or Scope of Practice

Services Rendered

Area or Geographic Range of Practice

Type of Facility

☐ Private Practice ☐ Clinic ☐ Hospital ☐ Other _____

ALTERNATE SUPERVISING RADIOLOGIST INFORMATION **(attach additional sheets if necessary)**

Alternate Supervising Radiologist #1	AR License Number
Complete Address (PO Box or Street, City, State, Zip Code)	

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

RADIOLOGIST ASSISTANTS CURRENTLY UNDER YOUR SUPERVISION		
Name of Radiologist Assistant currently under your supervision	Supervising or Alternate Supervising? ☐ Supervising ☐ Alternate	AR R.A. License Number
Name of Radiologist Assistant currently under your supervision	Supervising or Back-up Supervising? ☐ Supervising ☐ Alternate	AR R.A. License Number
Name of Radiologist Assistant currently under your supervision	Supervising or Back-up Supervising? ☐ Supervising ☐ Alternate	AR R.A. License Number

Supervising Radiation Practitioner's Signature

Date Signed

ARKANSAS STATE MEDICAL BOARD

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

ARKANSAS MEDICAL PRACTICES ACT and RULES 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 RULE 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.

_____
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: LICENSING
1401 W. Capitol, Suite 340
LITTLE ROCK, AR 72201

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol, Suite 340, Little Rock, AR 72201
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 (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.

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's or Alternate Supervising Radiologist's report to the referring physician consistent with the American College of Radiology Communication Guidelines.
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's or Alternate Supervising Radiologist's overall direction and control, but the Supervising Radiation Practitioner's 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 **(Gen**eral, **Dir**ect, or **Per**sonal). **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)
1. Non-Invasive Procedures			
Perform non-invasive imaging procedures under the supervision of the Supervising Radiation Practitioner or Alternate Supervising Radiologist.			
A. Gastrointestinal Studies	**A.** _____	**A.** _____	**A.** _____
1. Contrast Enemas (single and double contrast)	1. _____	1. _____	1. _____
2. Upper GI series	2. _____	2. _____	2. _____
3. Small Bowel series	3. _____	3. _____	3. _____
4. Barium Swallowing Studies	4. _____	4. _____	4. _____
5. Esophagram	5. _____	5. _____	5. _____
6. Sinus Tract Fistulagram	6. _____	6. _____	6. _____
7. Nasogastric tube replacement & repositioning	7. _____	7. _____	7. _____
B. Urogenital Studies	**B.** _____	**B.** _____	**B.** _____
1. Cystography	1. _____	1. _____	1. _____
2. Nephrostogram	2. _____	2. _____	2. _____
3. Voiding Cystourethrogram	3. _____	3. _____	3. _____
4. Loopogram	4. _____	4. _____	4. _____
5. Intravenous urography	5. _____	5. _____	5. _____
C. Biliary System	**C.** _____	**C.** _____	**C.** _____
1. T-tube cholangiogram	1. _____	1. _____	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 **(Dir**ect or **Per**sonal). **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)
2. Invasive Procedures Perform invasive imaging procedures under the supervision of the Supervising Radiation Practitioner or Alternate Supervising Radiologist.			
A. Venous Access - Placement	**A. _____**	**A. _____**	**A. _____**
1. PICC placement	1. _____	1. _____	1. _____
2. Non-Tunneled Central Venous Access	2. _____	2. _____	2. _____
3. Tunneled Central Venous Access	3. _____	3. _____	3. _____
4. Venous Port placement	4. _____	4. _____	4. _____
B. Venous Access - Removal	**B. _____**	**B. _____**	**B. _____**
1. PICC line removal	1. _____	1. _____	1. _____
2. Non-Tunneled CVL removal	2. _____	2. _____	2. _____
3. Tunneled CVL removal	3. _____	3. _____	3. _____
4. Venous Port removal	4. _____	4. _____	4. _____
5. Intravenous urography	5. _____	5. _____	5. _____
C. Fluid Aspiration Procedures	**C. _____**	**C. _____**	**C. _____**
1. Paracentesis	1. _____	1. _____	1. _____
2. Thoracentesis	2. _____	2. _____	2. _____
3. Superficial fluid collections	3. _____	3. _____	3. _____
4. Abscess tube placement	4. _____	4. _____	4. _____
5. Pleural drain placement	5. _____	5. _____	5. _____
D. Angiography	**D. _____**	**D. _____**	**D. _____**
1. Basic Femoral Venous non-selective Sheath Placement	1. _____	1. _____	1. _____
2. Basic Femoral Arterial non-selective Sheath Placement	2. _____	2. _____	2. _____
3. Perform non-selective aorto-iliac arteriography	3. _____	3. _____	3. _____
4. Perform non-selective Venography	4. _____	4. _____	4. _____
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.)	5. _____	5. _____	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 **(Dir**ect or **Per**sonal). **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)	**E. _____**	**E. _____**	**E. _____**
1. Gastrointestinal Tubes (e.g., Gastrostomy, Gastrojejunostomy, Jejunostomy, etc.)	1. _____	1. _____	1. _____
2. Genitourinary Tubes (Nephrostomy, etc.)	2. _____	2. _____	2. _____
3. Abscess Drainage Tubes	3. _____	3. _____	3. _____
4. Biliary Drainage Tubes (Internal, Internal/External, etc.)	4. _____	4. _____	4. _____
F. Drainage tube management/maintenance (Catheter Check/Change of Drainage Tubes)	**F. _____**	**F. _____**	**F. _____**
1. Simple Suturing & Retention Device Suturing	1. _____	1. _____	1. _____
2. Dressing Changes	2. _____	2. _____	2. _____
3. Drainage Bag Management/Evaluation	3. _____	3. _____	3. _____
G. Joint Aspiration and Lumbar Puncture	**G. _____**	**G. _____**	**G. _____**
1. Arthrography			
a. Shoulder	1a. _____	1a. _____	1a. _____
b. Knee	b. _____	b. _____	b. _____
c. Hip	c. _____	c. _____	c. _____
d. Wrist	d. _____	d. _____	d. _____
e. Elbow	e. _____	e. _____	e. _____
f. Ankle	f. _____	f. _____	f. _____
2. Neuroradiology			
a. Lumbar Puncture	2a. _____	2a. _____	2a. _____
b. Lumbar Myelography	b. _____	b. _____	b. _____
c. Thoracic Myelography	c. _____	c. _____	c. _____
d. Cervical Myelography	d. _____	d. _____	d. _____
e. Epidural Steroid injection	e. _____	e. _____	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 **(Dir**ect or **Per**sonal). **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	**H. _____**	**H. _____**	**H. _____**
1. Bone/Bone Marrow	1. _____	1. _____	1. _____
2. Liver	2. _____	2. _____	2. _____
3. Lung	3. _____	3. _____	3. _____
4. Soft Tissue	4. _____	4. _____	4. _____
5. Breast	5. _____	5. _____	5. _____
6. Kidney	6. _____	6. _____	6. _____
7. Pancreas	7. _____	7. _____	7. _____
8. Thyroid	8. _____	8. _____	8. _____
Additional Procedures			
I. _____	I. _____	I. _____	I. _____
II. _____	II. _____	II. _____	II. _____
III. _____	III. _____	III. _____	III. _____
IV. _____	IV. _____	IV. _____	IV. _____
V. _____	V. _____	V. _____	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.

Radiologist Assistant 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

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.

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.

RADIOLOGIST ASSISTANT

Radiologist Assistant's Name

ALTERNATE SUPERVISING RADIOLOGIST INFORMATION

Alternate Supervising Radiologist's Name			AR License Number
Complete Address (PO Box or Street, City, State, Zip Code)			
Office Telephone Number	Office Fax Number	Home Telephone Number	Mobile Telephone Number
E-mail Address		Specialty	Board Certified? ☐ Yes ☐ No
Type or Scope of Practice			
Services Rendered			
Area or Geographic Range of Practice			

Type of Facility

☐ Private Practice ☐ Clinic ☐ Hospital ☐ Other _____

PRIMARY SUPERVISING RADIATION PRACTITIONER INFORMATION

Primary Supervising Radiation Practitioner	AR 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? ☐ Supervising ☐ Alternate	AR R.A. License Number
Name of Radiologist Assistant currently under your supervision	Supervising or Back-up Supervising? ☐ Supervising ☐ Alternate	AR R.A. License Number
Name of Radiologist Assistant currently under your supervision	Supervising or Back-up Supervising? ☐ Supervising ☐ Alternate	AR R.A. License Number

Supervising Radiation Practitioner's Signature

Date Signed

Alternate Supervising Radiologist's Signature

Date Signed

ARKANSAS STATE MEDICAL BOARD

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

ARKANSAS MEDICAL PRACTICES ACT and RULES 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 RULE 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: LICENSING
1401 W. Capitol, Suite 340
LITTLE ROCK, AR 72201

ARKANSAS STATE MEDICAL BOARD

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@armedicalboad.org

ALTERNATE SUPERVISING RADIOLOGIST SCOPE OF PRACTICE STATEMENT

Rule 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:

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

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol, Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboad.org

VERIFICATION OF RADIOLOGIST ASSISTANT EDUCATION

PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – INSTITUTION NAME AND MAILING ADDRESS

Institution Name: .....

Department or Office: .....

Address Line 1: .....

Address Line 2: .....

City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX- ___ ___ ___ ___	Date of Birth (mm/dd/yyyy) / /
Other Names Used		Date of Graduation (mm/dd/yyyy) / /
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.		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III - VERIFICATION (TO BE COMPLETED BY DEAN, REGISTRAR OR AUTHORIZED REPRESENTATIVE ONLY)

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

Name of Radiologist Assistant School/Program (if not correct above)		
Date R.A. Education Began / /	Date R.A. Education Ended / /	Degree Awarded ❒ R.A. ❒ Other _____ ❒ 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? ❒ Yes ❒ No *[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.]*		

PART IV - VERIFIED BY

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

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

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol, Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboad.org

VERIFICATION OF LICENSURE

PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – LICENSING AUTHORITY NAME AND MAILING ADDRESS

Name of Licensing Authority: .....

ATTN: .....

Address Line 1: .....

Address Line 2: .....

City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX- ___ ___ ___ ___	Date of Birth (mm/dd/yyyy) / /
Other Names Used		License Number for this state or country

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.

Applicant Signature (no electronic or stamped signature)	Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY LICENSING AUTHORITY STAFF ONLY)

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

State/Country	Name of Licensing Authority (if not correct above)	
License Number	Original Issue Date (mm/dd/yyyy) / /	Expiration Date (mm/dd/yyyy) / /

Current License Status
❒ Active ❒ Inactive ❒ Temporary ❒ Other:_____

License Category
❒ Unlimited ❒ Educational ❒ Other:_____

Please answer the following questions and attach explanations and dates for any "Yes" answers.

Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction, or is any such investigation pending?	❒ Yes	❒ No
Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction, or is any such action pending?	❒ Yes	❒ No
Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state, or is any such action pending?	❒ Yes	❒ No

PART IV - VERIFIED BY

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

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

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol, Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboad.org

VERIFICATION OF HOSPITAL/CLINIC RADIOLOGIST ASSISTANT (or RADIOLOGY PRACTITIONER ASSISTANT) AFFILIATION

PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – FACILITY NAME AND MAILING ADDRESS

Name of Facility: .....

ATTN: .....

Address Line 1: .....

Address Line 2: .....

City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX- ___ ___ ___ ___	Date of Birth (mm/dd/yyyy) / /
Other Names Used		
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.		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY FACILITY AUTHORIZED STAFF ONLY)

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

Name of Facility (if not correct above)		
Current Staff Status ❒ Current ❒ Inactive ❒ Leave of Absence ❒ Other _____		
Date Affiliation Began (including temp or provisional) / /	Date Affiliation Ended / /	❒ If exact dates are not available, please check here. If currently appointed, please write "Present" in the space for end date.
Note: Breaks in appointment should be listed as separate entries. If the applicant was there intermittently, a listing of each time period he/she was appointed to your facility's ancillary staff should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing appointment dates.		
Current or most recent Position/Title		
To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed). ❒ Yes ❒ No ❒ Unknown/Unable to comment, Reason:		

PART IV - VERIFIED BY

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

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

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol, Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboad.org

VERIFICATION OF PROFESSIONAL LIABILITY INSURANCE

PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – INSURANCE CARRIER AND AGENCY NAME AND MAILING ADDRESS

Name of Insurance Carrier: .....

Name of Insurance Agency: .....

Address Line 1: .....

Address Line 2: .....

City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX-_____	Date of Birth (mm/dd/yyyy) / /
Policy Number	If Group Policy, name of Group	
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.		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY INSURANCE CARRIER OR AGENCY STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Insurance Carrier		Name of Agency/Producer	
Agency/Producer Address (if not correct in address block above)			
Policy Number	Date Coverage Began / /	Date Coverage Ends / /	Retroactive Date / /
Coverage Type ❒ Occurrence-based ❒ Claims-based ❒ Tail Coverage	Coverage Limits $ _____ / $ _____		
Have any specific procedures been excluded from this coverage? If yes, please list procedures.		❒ Yes	❒ No
Has your insurance company defended this provider in any professional liability suits?		❒ Yes	❒ No
Does your insurance company currently have any pending judgments or settlements on behalf of this provider?		❒ Yes	❒ No
Has your insurance company paid judgment or settlements on behalf of this provider?		❒ Yes	❒ No
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.			

PART IV - VERIFIED BY

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

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

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol, Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboad.org

VERIFICATION OF CURRENT MILITARY SERVICE

PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – MILITARY NAME AND MAILING ADDRESS

Name of Duty Station: .....

Name of Current Commanding Officer: .....

Address Line 1: .....

Address Line 2: .....

City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX – XX – ___ ___ ___ ___	Date of Birth (mm/dd/yyyy) / /
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.		
Applicant Signature		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY AUTHORIZED PERSONNEL ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the applicant cannot be accepted for verification purposes. Provide exact dates if possible.

Branch of Service		
Present Status ❒ Current ❒ Inactive ❒ Leave of Absence ❒ Other _____		
Date Service Began / /	Date Service Ended / /	❒ If exact dates are not available, please check here. If currently in the military, write "Present" in the space for end date.
Current or Most Recent Position/Title		
To your knowledge, during the stated period of time, was the applicant in good standing? If No, please explain (attach additional sheets if needed). ❒ Yes ❒ No ❒ Unknown/Unable to comment		

PART IV - VERIFIED BY

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

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL

(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

Inactive U.S. military personnel should provide proof of service by submitting a copy of his/her DD Form 214 with their application in lieu of completing this form.

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol, Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboad.org

CHANGE TO PRACTICE SPECIFIC DOCUMENT (ALTERNATE SUPERVISING RADIOLIGIST)

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: LICENSING
1401 West Capitol, Suite 340
LITTLE ROCK, AR 72201