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from a source other than directly from the Arkansas State Medical Board or its official website, the application may be outdated or not an official version. Please be advised that outdated or unofficial versions of the application cannot be accepted.

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

PROCESSING TIME. Processing delays are almost always attributable to lengthy work histories and delays in receiving the verification documents you request. If you have a history of malpractice, disciplinary action, impairment history, etc., additional time will be required for our investigation. Processing a permanent license application will take several weeks to complete. Please plan for this. Do not make commitments, purchase a home, or relocate your family before your Arkansas Occupational Therapy license has been granted. Applications are processed in the order in which they are received in our office. The board does NOT accelerate one applicant over another.

APPLICATION FEES. The fee for an Occupational Therapy license is $75; for an Occupational Therapy Assistant is $50. There is an additional $25 fee if you are requesting that a temporary permit be issued prior to full licensure. Fees must be included with your application at the time of submission. Payment may be made by check or money order payable to ASMB.

ARKANSAS MEDICAL PRACTICES ACTS AND REGULATIONS. The Arkansas Occupational Therapy Act (Arkansas Code §17-88-101, et seq.) must be read in its entirety prior to submitting an application for an Occupational Therapy or Occupational Therapy Assistant license to the Arkansas State Medical Board. You MUST complete the Rules & Regulations Affidavit included in this packet. Applications received without this form will be returned. A copy of the Arkansas Occupational Therapy Act is included in this packet and is part of the Arkansas Medical Practices Acts and Regulations, which can be viewed and downloaded in the Forms & Publications section of our website, www.armedicalboard.org/Professionals/pdf/mpa.pdf.

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

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

(2) The applicant shall be responsible for payment of the fees associated with the background checks. Upon receipt in this office of your completed application and fee, a CBC packet, including forms and instructions, will be sent to you for completion. The Federal portion of this background check can take 4 to 6 weeks or more to process. ASMB will NOT accept a previously obtained criminal background check, regardless of how recently it was performed or what organization provides it.
COMPLETING THE APPLICATION. READ THE INSTRUCTIONS FOR EACH QUESTION BEFORE ANSWERING. The application may NOT be submitted electronically, as we do require your original signature on the hard copy. Please 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.” All signatures must be the applicant’s; stamped signatures, signatures by proxy, and signatures by power of attorney are NOT accepted for documentation or verification purposes. Make sure all required seals are affixed on the application, all questions have a response, and all documentation has been certified. Your application and verifications will be returned to you if they are incomplete or if photos are not attached where required.

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

“YES” RESPONSES. A “Yes” response in the attestation portion of the application does not mean your application will be denied. If you have responded “Yes” to any 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.

VERIFICATIONS. It is the policy of this board that ALL education and professional affiliations and other activities since graduation from Occupational Therapy School be verified by the primary source and reviewed by the full board prior to issuance of a permanent license. It is the applicant’s responsibility to request verifications and to follow up with organizations to ensure verifications are returned. All verifications can be faxed or e-mailed unless specifically requested to be mailed. To fax, send to (501) 296-1972, Attn: Licensing - OT. To e-mail, the document must be attached as an Adobe PDF file and sent to support@armedicalboard.org with “Attn: Licensing - OT” 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 never be received by the intended recipient.

INTERNATIONAL GRADUATES. If you are foreign-trained, the Arkansas State Medical Board must have on file a copy of your current Visa.

CHECKING THE STATUS OF YOUR APPLICATION. The Arkansas State Medical Board’s required form of communication is an interactive Applicant Checklist system that 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. You may access the Applicant Checklist system from any computer at any time by visiting the Medical Board’s web site at: http://www.armedicalboard.org. You will click the "Applicant Checklist" link, located on the left, to access this secured web address. You must enter a FileID which will be provided to you via e-mail once work on your application has started and a copy of your résumé is received. You will also need your date of birth and the last 4 digits of your SSN to access this secure system. Be sure to review the "How to Use the Checklist System" once you have successfully logged into the site.

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

This interactive system allows the licensing 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.

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

**TEMPORARY PERMITS.** You may request that a temporary permit be granted only if you meet the educational requirements and have NOT passed the NBCOT examination, so that you can begin working in Arkansas before the Board considers your request for a permanent license. Temporary permits can be issued only when every detail of the application process has been completed and is ready for Board approval. Temporary permits must be requested on the application and the required fee of $25 must accompany your request. Temporary permits expire 30 days after the NBCOT eligibility date, and can be extended only by submitting a written request and an additional $25 fee. Issuance of a temporary permit does NOT guarantee that a permanent license will be granted. Completed files are submitted to the Board each Thursday for consideration of a temporary permit, and all temporary permits granted can be verified online (http://www.armedicalboard.org/public/verify/default.aspx) on the following Friday after 2:00pm.

**APPEARING BEFORE THE BOARD.** For your application to be placed on the Board Meeting agenda, it must be complete and all required documentation, including staff investigations, must be in this office by the deadline date. THERE ARE NO EXCEPTIONS TO THIS POLICY. Applicants who have disciplinary actions and/or impairment history may be required to make a personal appearance before the Board. If you are required to make a Board Appearance, you will be notified of the time and date of your appearance prior to the next scheduled Board Meeting.

**U.S. POSTAL SERVICE.** If you choose to utilize the U.S. Postal Service, please be advised that they do NOT guarantee delivery of first class mail, and they do NOT guarantee delivery of Certified mail. Based on the lengthy delays we have experienced in receiving mail that has been sent to us, we strongly recommend you utilize FedEx, UPS, or other guaranteed delivery service when sending your application or other documents to us. We further recommend that when sending verification requests to primary sources, you provide them with a prepaid FedEx, UPS or other delivery service envelope to ensure that their correspondence reaches us in a timely manner.

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

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

**LICENSE RENEWAL.** Your Occupational Therapy or Occupational Therapy Assistant license, if granted, must be renewed annually on or before the last day of your birth month. Your first renewal notification will be sent to you via 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 accessed a $25.00 late fee to reinstate your license and you will be required to submit copies of your certificates of
completion for continuing education units. *****REMINDER ***** It is illegal to practice occupational therapy in this state on an inactive or lapsed license or permit.

**CHANGE OF ADDRESS.** Regulation 33 requires you to notify the Arkansas State Medical Board of any changes to your address within 30 days of such change. This includes your relocation to Arkansas, if applicable.

**SUPERVISING OCCUPATIONAL THERAPIST.** By law, Occupational Therapy Assistants are allowed to practice only under the supervision of a licensed Occupational Therapist. It is the responsibility of the OTA to keep this office informed of your current Supervising OT in Arkansas.
ARKANSAS MEDICAL PRACTICES ACTS 17-88-302: OCCUPATIONAL THERAPIST AND OCCUPATIONAL THERAPY ASSISTANTS MUST MEET THE FOLLOWING CONDITIONS:

(1) Must be at least 18 years of age.
(2) Must be of good moral character.
(3) Must have successfully completed the academic requirements of an educational program in Occupational Therapy with concentration in biologic or physical science, psychology and sociology, and with education in selected manual skills:
   (A) For an Occupational Therapist, the program shall be accredited by the American Medical Association in collaboration with the American Occupational Therapy Association and shall lead to the awarding of a bachelor’s or master’s level degree or advanced standing certification in occupational therapy.
   (B) For an Occupational Therapy Assistant, the program shall be approved by the American Occupational Therapy Association and shall lead to the awarding of an associate level degree in occupational therapy;
(4) Must have successfully completed a period of supervised field work experience at a recognized educational institution where he or she met the following academic requirements:
   (A) For an occupational therapist, a minimum of six (6) months supervised field work experience is required;
   (B) For an Occupational Therapy Assistant, a minimum of two (2) months of supervised field work experience at an approved facility other than the one at which the person was previously employed, if applicable, is required;
(5) Must have passed an examination conducted by the Board as provided in Sec. 17-88-304.
(6) Must complete a background check as defined in Arkansas Medical Practices Act Section 17-95-306.
(7) Must present indisputable identification.
(8) Must submit a completed application with a licensure fee of $75 for Occupational Therapist, $50 for Occupational Therapy Assistant.

LICENSURE IS BY CREDENTIALS:
  ▪ Credentials must be verified from the originating source; verifications received from applicants will not be accepted.

LICENSING EXAMINATIONS MEETING THE BOARD REQUIREMENTS ARE AS FOLLOWS:
  ▪ NBCOT
You are required to provide the following documents to the Arkansas State Medical Board:

- Check or money order, made payable to ASMB, in the amount of $75 for Occupational Therapy, $50 for Occupational Therapy Assistant. Add $25 if also requesting a temporary permit on either license;
- Application (5 pages), signed, with passport-style photo and certification by Notary Public. Signature must be original and must be made in black or dark blue ink. Stamped signatures, signatures by proxy and signatures by Power of Attorney are NOT accepted;
- Signed and dated explanations for any “Yes” answers in Part IV of the Application;
- Signed and dated explanations for any time gaps of 30 days or more since the end of occupational therapy school;
- Completed Occupational Therapy Authorization and Release (form in packet);
- Completed Arkansas Medical Practices Acts and Rules and Regulations Affidavit (form in packet);
- Copy of Driver’s License or Passport;
- Copy of name change documents, if applicable;
- Copy of proof of citizenship, naturalization, or visa, 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 since occupational therapy school;
- Copy of current résumé.

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:

- NBCOT Certification Verification  (if you have taken and passed the examination)
  Go to www.nbcot.org to request a verification of certification be sent directly to this office.
- NBCOT Score Report  (if you have not yet taken and passed the examination)
  Go to www.nbcot.org to apply for the exam and to request an “Official Score Transfer” to the State of Arkansas. There is a fee for this service. Please Note: ASMB will not receive a report unless you select this option and pay for this service. Failing to order this service from NBCOT will delay your file for licensure.
- Verification of Occupational Therapy Education and Official Transcript  (form in packet)
  Complete Parts I and II of this form, and send to the Dean or Registrar of occupational therapy school/program you attended. The completed form and transcript must be sent directly from the source to this office.
- 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/Facility Affiliation** (form in packet)
  Complete Parts I and II of this form, and then send a copy to the Department Director or Administration Office of every facility that has granted you Occupational Therapy privileges or has employed you as an OT or OTA in the last five (5) years. The completed form or an equivalent verification letter must be sent directly from the source to this office.

- **Verification of Military Service**
  If you are still in the armed forces, request that your current Commanding Officer submit a verification letter directly to this office. If you are former military, you only need to provide a copy of your DD Form 214 if you have served since graduating occupational therapy school.

- **Verification of Employment (Non-Therapy)** (form in packet)
  Complete Parts I and II of this form, and then send a copy to every employer where you have worked in a non-therapy-related position within the last five (5) years, or since graduating from occupational therapy school, whichever is shorter. The completed form or an equivalent verification letter must be sent directly from the source to this office.

- **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
Request for Temporary Permit:
Check either Occupational Therapy or Occupational Therapy Assistant. If you wish to obtain a temporary permit prior to full licensure, please note: You are eligible for a temporary permit only if you have not yet taken or passed the NBCOT examination. If you fail the examination the first time, you will only be eligible to receive one more temporary permit to give you the opportunity to take the examination a second time.

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

c. Check male or female.
d. Enter your date of birth (mm/dd/yyyy).

e. Enter your Social Security number.

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).

e. Enter the full name of the occupational therapy school/program where you completed your Occupational Therapy or Occupational Therapy Assistant undergraduate and graduate (if applicable) education. Complete Parts I and II of the “Verification of Occupational Therapy Education” form contained in the application packet and send one to the school. This form should only be completed and submitted after graduation; any forms submitted before graduation are invalid and must be submitted again. Forms must be returned directly to this office from the institution.

Question 3: Birthplace/Citizenship
a. Enter your place of birth (city and state, or city and country).
b. Enter the name of the country in which you hold citizenship. If you are a U.S. citizen, enter “U.S.A.” If you are a U.S. citizen born in a foreign country, you must submit proof of citizenship.
c. Indicate your immigration status. If you are a U.S. citizen, enter “n/a.” If you are not a U.S. citizen, you must submit a copy of your current visa.
d. Indicate how long 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.

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

g. Enter your personal email 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. If you do not know your intended practice location, enter “Unknown.”
b. Enter the mailing address of the hospital, clinic, group or private practice where you will be practicing. If you do not know your intended practice location, enter “Unknown.”

c. Enter the mailing address of the hospital, clinic, group or private practice where you will be practicing.

d. Enter the date you started attending the school/program.

e. Enter the date you graduated the school/program.

Question 6: Education
a. Enter the full name of the occupational therapy school/program where you completed your Occupational Therapy or Occupational Therapy Assistant undergraduate and graduate (if applicable) education.
b. Enter the mailing address of the hospital, clinic, group or private practice where you will be practicing. If you do not know your intended practice location, enter “Unknown.”
c. Enter your private, work, fax, and mobile phone numbers in the appropriate spaces.
d. Enter your personal email 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 7: Examination
Answer “Yes” if you passed the NBCOT examination, “No” if you did not. If you have taken and passed the exam, have certification verification from NBCOT mailed directly to this office. If you have not taken and passed the exam, have NBCOT send an Eligibility to Examine Notice directly to this office. Upon notification from NBCOT that you have successfully completed the examination, and your score, you are eligible for full licensure. You will need to be certain your application file is complete. Your full license cannot be granted until all documents and verifications are received.
Question 8: Licenses
a. If you have never held an OT or OTA 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 OT or OTA license in another state or country, enter the name of that state or country here. Additional sheets may be attached, if necessary.
b. Enter your OT or OTA license number.
c. Enter the date the OT/OTA license was originally issued.
d. Enter the date the OT/OTA 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 have ever served in the armed forces of the U.S. or any other country since graduating from Occupational Therapy 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, have your current Commanding Officer submit a verification letter directly 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. Additional sheets may be attached, if necessary. You must list all professional activities since graduation from occupational therapy school. Do NOT enter “See résumé.” If you ever took a leave of absence of more than 30 days from an employer, or if there was a gap of 30 days or more between the end of one activity and the beginning of the next, you must provide a separate, signed and dated explanation for the time gap. Complete Parts I and II of the “Verification of Hospital/Facility Affiliation” and send one to the appropriate department at each hospital, clinic, group or private practice where you worked as an OT or OTA within the past five (5) years. Complete Parts I and II of the “Verification of Employment (Non-Therapy)” and send one to the appropriate department at each place you have worked that is non-therapy-related within the last five (5) years, or since graduating from occupational therapy 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).

Question 11: Professional References
a. Enter the names of three (3) professional references (not related to you). These references must have worked with you and directly observed your work performance in the recent past. At least one of these references must have had organizational responsibility for supervising your performance (i.e., department chief or training program director).
b. Enter how this person is associated with you (instructor, program director, etc.).
c. Enter the mailing address (including the organization they are with) for this reference.

Questions 12-19 (Attestation Questions):
For each “YES” response to questions 12 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. 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 QUESTIONS 12 and 13:
You must attach a copy of the original indictment, judgment or conviction, indicate whether paroled or placed on probation, and how probation was completed. If you have or had a record that was sealed, expunged or pardoned, you are still required to answer “Yes” to this question.

Affidavit of Applicant (Signature Page):
Read the affidavit completely before signing. Attach a passport-style photo taken within the past sixty (60) days in the space shown. You must sign where indicated IN THE PRESENCE OF A NOTARY PUBLIC, swearing you are the person referred to in the application and that all statements contained therein are true and correct. The Notary’s date must match your signature date. The Notary seal should be affixed partially on the photograph. Applications received without a photo or the required Notary seal will be returned to the applicant for completion, thereby delaying the application process.
APPLICATION FOR OCCUPATIONAL THERAPY LICENSURE IN ARKANSAS

1. Please read the IMPORTANT INFORMATION and ALL INSTRUCTIONS included in the application packet.
2. Type or print legibly (in dark blue or black ink) all application documents.
3. Provide exact dates whenever possible, in mm/dd/yyyy format.
4. All questions must be answered. If a question does not apply to you, please write “n/a” in the space provided.
5. Give careful thought to each question before answering; remember, you are certifying that the information you provide is truthful, complete and correct.
6. If you answer “Yes” to any question in Part IV of the application, you MUST submit a signed and dated explanation.
7. Failure to answer all questions completely and accurately, or the omission or falsification of information, may be cause for denial of your application or disciplinary action if you are subsequently granted a license. WHEN IN DOUBT, DISCLOSE AND EXPLAIN ALL INFORMATION.

TYPE OF LICENSE YOU ARE APPLYING FOR (check one)
- [ ] Occupational Therapy
- [ ] Occupational Therapy Assistant

Are you requesting that a temporary license be issued prior to full licensure?
- [ ] Yes
- [ ] Not at this time

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
- [ ] 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)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Application Received: / / Fee Received: $

1st Temp Permit #:
1st Temp Issued: / / 1st Temp Expires: / /

2nd Temp Permit #:
2nd Temp Issued: / / 2nd Temp Expires: / /

OT/OTA License #:
Full License Issued: / /
PART II - EDUCATION

UNDERGRADUATE AND GRADUATE EDUCATION

List all occupational therapy schools/programs you attended (attach additional sheets if necessary). Have each school complete and mail the Verification of Education form directly to this office.

6a. Full Name of Institution and Program

6b. Mailing Address (Street Address, City, State, Zip Code)

6c. Start Date
6d. End Date
6e. Graduated? □ Yes □ No
6f. Degree Awarded, or reason why you did not graduate

EXAMINATION HISTORY

7. Have you passed the NBCOT Exam? □ Yes □ No

If Yes, have NBCOT send the Verification of Certification to this office.
If No, have NBCOT send the Eligibility to Examine Notice to this office and request an Official Score Transfer.

7a. Exam
7b. Number of Attempts
7c. Number of times failed
7d. Date PASSED

7a. Exam
7b. Number of Attempts
7c. Number of times failed
7d. Date PASSED

7a. Exam
7b. Number of Attempts
7c. Number of times failed
7d. Date PASSED

7a. Exam
7b. Number of Attempts
7c. Number of times failed
7d. Date PASSED

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 an Occupational Therapy license, including all temporary, instructional, and training permits/licenses. 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 your current commanding officer submit a verification letter directly to this office.

9a. Have you ever been in the armed forces since graduating from occupational therapy school? □ 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 therapy and non-therapy work history and other activities, including hospitals, private practice, employment, time gaps and leaves of absence since graduation from Occupational Therapy school. You must provide explanations of any time gaps and leaves of absence of more than 60 days since graduation from Occupational Therapy School. Do not write, “See résumé.”

<table>
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<tr>
<th>10a. Name of Institution/Facility/Employer</th>
<th>10b. Mailing Address (Street or PO Box, City, State, Zip Code)</th>
<th>10c. Date FROM</th>
<th>10d. Date To</th>
<th>10e. Title/Position</th>
<th>10f. Status</th>
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PROFESSIONAL REFERENCES

These references cannot be related to you. They must have worked with you and directly observed your work performance in the recent past. At least one of these references/recommendations must have had organizational responsibility for supervising your performance (i.e., department chief or training program director).

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<th>11a. Name</th>
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<th>11c. Mailing Address (Organization, Street or PO Box, City, State, Zip Code)</th>
<th>11a. Name</th>
<th>11b. Association</th>
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PART IV - ATTESTATION QUESTIONS

SPECIAL INSTRUCTIONS FOR QUESTIONS 12-19

• Please mark the appropriate box next to each question. Do not leave any questions blank.
• For each “Yes” response to questions 12-19, 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.
• Confidentiality: The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a “Yes” answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.

12. Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony? (NOTE: You must answer “Yes” even if records, charges, or convictions have been pardoned, expunged, plead down, released, or sealed.) If yes, explain.
   □ No □ Yes

13. Have you had a DWI or DUI conviction in the last three (3) years? How many? ______ If yes, explain.
   □ No □ Yes

14. 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 Occupational Therapy? If yes, explain.
   □ No □ Yes

15. Have you ever been addicted to alcohol or drugs? If yes, explain.
   □ No □ Yes

16. Have you ever been treated for alcohol/substance abuse in a treatment center or hospital? If yes, give name of institution, date and length of stay in your explanation.
   □ No □ Yes

17. Has any medical or occupational therapy licensing board or NBCOT ever sanctioned you or your certification? If yes, list name and address of board/entity in your explanation.
   □ No □ Yes

18. Have you ever voluntarily surrendered your OT license in any other jurisdiction, state or territory? If yes, give name and address of board in your explanation.
   □ No □ Yes

19. Have you ever previously made application to the Arkansas State Medical Board? If yes, explain.
   □ No □ Yes

continue to next page

DO NOT WRITE EXPLANATIONS IN THIS SPACE.
PART V - AFFIDAVIT OF APPLICANT

I, _______________________________________________, hereby certify, after being duly sworn, that I have read the complete application and know the full content thereof. I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true, correct, current, and complete to the best of my knowledge. I certify that the photograph that appears below is a true likeness of me, taken within the past sixty (60) days. I understand that any falsification or misrepresentation of any item or response in this application, or any documentation supporting this application, even if submitted separately, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice as an Occupational Therapist or Occupational Therapy Assistant in the State of Arkansas.

Applicant’s Signature (in ink)
(must be signed in the presence of a Notary Public)

Date Signed
(must include the month, day and year signed)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the State of ________________________________, this ______ day of ______________, 20___.
(Notary date must be the same as the applicant’s signature date above)

My commission expires: _____________________

Notary Signature
(Notary seal must overlie a portion of the photograph at left)
ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT
Occupational Therapy / Occupational Therapy Assistant


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

Practitioner'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 AVE, SUITE 340
LITTLE ROCK, AR 72201
To practice lawfully, you must know the legal requirements pertaining to your profession. The following questions represent a sample of the law and regulations governing the practice of Occupational Therapy in the State of Arkansas, §17-88-101 through §17-88-312 and Regulation No. 6.

It is your professional responsibility to know the legal requirements surrounding the practice of your profession and be alert to changes in those requirements. This questionnaire is intended to provide you with a measure of your working knowledge of those requirements. You will find the answers within the OT Practice Act available online at our website, www.armedicalboard.org. This questionnaire is an extension of the Rules and Regulations Affidavit, also enclosed. Both documents must be returned with your application.

This document may also be submitted to the Arkansas State Medical Board for (1) CEU credit (limit one per renewal cycle). Questions will be modified at the discretion of the Occupational Therapy Examining Committee.

Name of OT or OTA: ____________________________ Date: ____________

Write the letter of the correct answer.

1. All Occupational Therapists and Occupational Therapy Assistants licensed by the Board in the State of Arkansas must complete ten (10) CEUs as a condition for licensure renewal.
   a) True
   b) False

2. It is unlawful for any person who is not licensed under the Occupational Therapy Practice Act as an OT or OTA or whose registration has been suspended or revoked, to use, in connection with his or her name or place of business, the words “Occupational Therapist”, “Occupational Therapy Assistant”, or letters “O.T.” or “O.T.A.” to imply he or she is an occupational therapist or occupational therapy assistant:
   a) True
   b) False

3. “Occupational therapy” means the evaluation or treatment of individuals whose ability to cope with the tasks of living is threatened or impaired by developmental deficits, the aging process, poverty or cultural differences, environmental or sensory deprivation, physical injury or illness, or psychological and social disability.
   a) True
   b) False

4. At the Board’s discretion, delinquent licenses of less than five (5) years may be reinstated by:
   a) Providing proof of completion of continuing education for each year
   b) Paying all delinquent fees and fines
   c) Completing the renewal application provided by the Board
   d) All of the above
   e) None of the above

5. Excess CEUs may be carried over into the next renewal period:
   a) True
   b) False
6. _______ Annual license renewals are due:
   a) First day of the year
   b) Last day of the year
   c) Last day of birth month
   d) First day of birth month

7. _______ Continuing education must pertain to the field of medicine.
   a) True
   b) False

8. _______ The Arkansas State Medical Board may revoke, suspend, refuse to renew a license or permit, place on probation or reprimand a licensee or permit holder, or deny a license to:
   a) A licensee/applicant who has been found to have violated any Rules or Regulations of the Arkansas State Medical Board Practices Acts.
   b) A licensee who does not renew their license.
   c) A licensee who renews their license 30 days before it expires.
   d) A licensee who fails to show their license registration card when asked by a member of the public.
   e) All of the above.

9. _______ Any person may file a complaint with the Arkansas State Medical Board regarding a licensee:
   a) True
   b) False

10. _______ Once I pass the NBCOT exam, I am able to practice in the State of Arkansas:
    a) True
    b) False

11. _______ Before an OTA can assist in the practice of occupational therapy, they must file with the Board a signed, current statement of supervision of the licensed occupational therapist(s) who will supervise the OTA. Change in supervision shall require a new status report to be filed with the Board.
    a) True
    b) False

12. _______ An aide shall not act independently or without on-site, in-sight supervision of a licensed occupational therapist during patient therapy sessions.
    a) True
    b) False

13. _______ The OTs shall assign, and the OTA shall accept, only those duties and responsibilities for which the OTA has been specifically trained and is qualified to perform, pursuant to the judgment of the OT.
    a) True
    b) False

14. _______ How many years must you maintain proof of the completed continuing education courses should they be requested by the Board/Occupational Therapy Examining Committee?
    a) 1
    b) 2
    c) 3
    d) Indefinitely

15. _______ A self-study of a journal review for CEU credit must include a typewritten review of the material studied.
    a) True
    b) False
AUTHORIZATION AND RELEASE

To Whom It May Concern:

This document will authorize and direct any healthcare practitioners with whom I have been associated; employees and medical staff members of any medical facility or hospital where I have been employed, on staff, or associated; any employees of any malpractice insurance carriers; any state licensing boards where I have been licensed or have applied for a license; any medical clinics where I have been employed or associated; and any medical schools where I have attended, to give to, copy for, or permit the personal inspection by employees or representatives of the Arkansas State Medical Board of any and all personnel records, disciplinary records, work records, military records, professional performance reviews, and/or evaluations of my performances.

I hereby release and discharge you and any other individuals or organizations referred to in this Authorization, and release you of any confidentiality requirements that might bind you, so that you may carry out the purposes of this document.

A copy of this document may be provided to entities listed above, and this Authorization shall remain in effect for a period not to exceed two (2) years or until specifically revoked by me in writing.

Typed or Printed Name of Practitioner: ____________________________

Social Security Number: _________________________________________

Signature of Practitioner: _______________________________________

_________________________  
Dark Blue or Black Ink Only - No Signature Stamps

Signature Date: ____________________________________________

OT Board A&R (10/29/10 QI; Rev. 4/18/12 QI; 12/31/13 BLE; 10/8/15 BLE)
So that the licensing process might be made easier for both you and the Board, your Application 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 Application Coordinator is working with over 100 applicants at any given time, and that repeated phone calls to check on the status of your application will only delay the processing time for all applicants. We appreciate your consideration of this.

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

Print full name of Secondary Contact _____________________________

Organization Name __________________________________________

E-mail address of Secondary Contact ______________________________

Phone number of Secondary Contact ______________________________

Print full name of Applicant _________________________________

Signature of Applicant (no signature stamps) _______________________

Date Signed ____________________________
VERIFICATION OF OCCUPATIONAL THERAPY 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. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Occupational Therapy School (if not correct above) ____________________________________________

Date O.T. Education Began / / 
Date O.T. Education Ended / / 
Degree Awarded (ex: Master of Occupational Therapy) ____________________________

If program was not completed, or was completed in more or less than the customary time frame for such training, please provide explanation (use additional sheets if necessary)

During this applicant’s education, was he/she ever investigated or disciplined by the school for any reason? [Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted or otherwise disciplined. If you respond “Yes” to this question, please provide a detailed explanation on a separate sheet, signed and dated by the person whose signature appears below.]

No ☐ Yes ☐

PART IV - VERIFIED BY

Verification provided by (Signature) ____________________________
Signature Date / / 

Type or legibly print name ____________________________
Position/Title ____________________________
Phone Number ____________________________
Fax Number ____________________________
E-mail Address ____________________________

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

ARKANSAS STATE MEDICAL BOARD
OCCUPATIONAL THERAPY LICENSURE DEPARTMENT
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

DATE OF REQUEST: ____________________________
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

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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.

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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)

OT FORM: Verification of Licensure (10/29/10 QI; Rev. 4/18/12 QI; 12/31/13 BLE; 10/8/15 BLE)
## PART I – FACILITY NAME AND MAILING ADDRESS

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<td>Address Line 2:</td>
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<td>City, State, ZIP Code:</td>
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## PART II – APPLICANT INFORMATION

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**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.

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<td>Current Staff Status</td>
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<td>☐ Current ☐ Inactive ☐ Leave of Absence ☐ Other</td>
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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. Thank you.

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 __________________
VERIFICATION OF EMPLOYMENT (Non-Therapy)
(for verification of employment that did not involve occupational therapy)

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

PART I – EMPLOYER NAME AND MAILING ADDRESS

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Applicant Signature (no electronic or stamped signature) | Date Signed (mm/dd/yyyy)
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PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER 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.

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Date Employment Began | Date Employment Ended |
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☐ If exact dates are not available, please check here.
If currently employed, please write “Present” in the space for end date.

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates. Thank you.

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
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Type or legibly print name

Phone Number | Fax Number | E-mail Address
|-------------|-----------|----------------|