



Arkansas Department of Health

5800 West Tenth St. Suite 400 • Little Rock, Arkansas 72204 • Telephone (501) 661-2201

Governor Asa Hutchinson

Renee Mallory, RN, BSN, Interim Secretary of Health

Jennifer Dillaha, MD, Director

Please type or write legibly. All mail will be sent to the address listed in item #3 without regard to any other address which may appear on this completed application or on the envelope in which it was mailed.

APPLICANT INFORMATION (Check one) Perfusionist _____ Provisional Perfusionist _____

1. Name: _____
Last First Middle or Maiden

2. Date of Birth: _____

3. Mailing Address: _____

4. Telephone: Home: _____ Work: _____ Cell: _____

5. E-mail Address: _____

6. Identify all professional licenses, certifications or registrations issued by jurisdiction or territory on back of this page or provide copy.

7. 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 ___

8. Have you ever had your license, certificate, or registration revoked, canceled, or suspended? Yes ___ No ___ If yes, briefly state the reason(s) on back of this page or attach report.

9. Please place a checkmark by the type of license for which you are applying:

_____ **Licensed Perfusionist**

Applicant must hold a current certification as a Certified Clinical Perfusionist (CCP) issued by the American Board of Cardiovascular Perfusion (ABCP).

___ **Enclose** a copy of the certificate or submit a verification letter from the ABCP.

___ **Enclose** an official transcript or copy of certificate of completion from an approved education program.

_____ **Provisional Licensed Perfusionist**

Applicant must have successfully completed an approved education program and shall be under the supervision and direction of a currently licensed perfusionist who resides in the state of Arkansas. _____

Enclose a copy of the certificate of completion from the education program. _____

Complete and enclose the *Statement of Supervision* form, page 4 of application. _____

EMPLOYMENT INFORMATION

10. Primary Employment Setting:

Position: _____ Dates of Employment: _____

Place of Employment: _____

Address (include zip code): _____

Telephone Number: _____

11. Secondary Employment Setting:

Position: _____ Dates of Employment: _____

Place of Employment: _____

Address (include zip code): _____

Telephone Number: _____

12. Work Experience:

List positions held, type of work performed, employer's name, address, and dates of employment for previous work experience in the field of perfusion:

ACADEMIC INFORMATION

Applicants must submit official transcripts from an approved program or from a program with requirements as stringent as those established by the Accreditation Committee for Perfusion Education (AC-PE) and approved by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or their successors. If submitting an equivalent program, the burden is on an applicant to establish that program requirements are as stringent as those by the AC-EP and approved by the CAAHEP or their successors.

13. List all colleges, universities, and educational programs attended. Attach additional sheets if necessary.

A. Perfusion education program: _____

Location: _____

Inclusive dates attended: _____

B. College or university: _____

Location: _____

Inclusive dates attended: _____

Degree awarded and major field: _____

PERFUSIONIST LICENSURE APPLICATION AFFIDAVIT & AGREEMENT

In making application to the State of Arkansas for a license or provisional license as a perfusionist, I have read and agree to abide by the Perfusionist Licensure Act and the *Rules and Regulations for Perfusionists in Arkansas*. I also agree to complete all application requirements and take all examinations necessary for the processing of my application. Upon issuance of a license, I agree to be bound by the Code of Ethics. I further understand that the fee submitted with this application is non-refundable and that the materials submitted for consideration become the property of the State and are non-refundable. I am aware of the schedule of fees and understand that additional fees must be paid to keep the license current. I have read and fully understand the Section relating to changes of name and address within 30 days of that change.

I hereby grant permission to the State of Arkansas to seek any information or references it deems fit in securing my credentials pertinent to this application.

I further agree that if issued a license, upon the revocation, suspension or cancellation of that license, I shall return the license certificate and license identification card to the Committee.

As an applicant for a Perfusionist license in Arkansas, I swear or affirm on oath and under penalty of Arkansas law the following:

- OR
- _____ I am a United States citizen or a legal permanent resident 18 years of age or older.
- _____ I am a qualified alien or non-immigrant under the Federal Immigration and _____ Nationality Act; I am 18 years of age or older; I am lawfully present in the United States; and my alien or admission number is: _____
- (Print alien or admission number (required))

A front and back copy of one of the following documents must be attached:

1. Valid Foreign Passport with I-94; or
2. Temporary Resident Alien Card (I-688); or
3. Employment Authorization Card (I-766 or I-688B); or
4. Employment Authorization Document (I-688B); or
5. Refugee Travel Document (I-571)

The disclosure of a social security number is required under the Federal Code. Social Security numbers are used for identification purposes and are confidential except as to the child support enforcement division of the Office of the Attorney General.

The information which I have provided in this application is truthful. I understand that providing false information of any kind may result in the voiding of this application, and my failing to be granted a license or provisional license, or the revocation of my license. Licensing information is public and subject to FOIA.

Please include a check for **\$150.00** made out to [Arkansas Department of Health](#).

Failure to include all the above requested information, certificates, transcripts, and all 4 pages of original signed application will cause application to be returned for completion.

Date: _____ Perfusionist Signature: _____

STATEMENT OF SUPERVISION FOR PROVISIONAL LICENSED PERFUSIONIST

*The **supervising licensed Perfusionist** **must sign** 1. the application for a provisional license and 2. the application for renewal of the provisional license.*

Applicant Under Supervision Supervising Licensed Perfusionist

Name Legible Name - Supervising Licensed Perfusionist

Address Address

City, State, Zip City, State, Zip

Telephone Telephone

Provisional License Number Arkansas Perfusionist License Number

1. Applicant's number of cases worked per week: _____

2. _____
Primary location and setting of services rendered

3. _____
Address/City/State/Zip

4. _____
Description of services rendered by applicant

5. _____
Date employment will begin Date supervision will begin

Signature of Supervisee Signature of Supervisor

Date Date