ARKANSAS BOARD OF PODIATRIC MEDICINE

APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE

1. Name:_____ Social Security Number: _____
(As to appear on License)

2. Address: _____

3. Address you wish License to be mailed: _____

4. Telephone: (Res.)_____ (Work)_____

(Fax)_____ (Email) _____

5. ☐ Male ☐ Female Date of birth:_____ Place of Birth:_____

If born outside the U.S., how long have you lived in the U.S.? Years:_____ Months:_____

Are you a U.S. citizen ☐ Yes ☐ No **If yes and foreign born, attach proof of citizenship.**

If no, indicate your status with U.S. Immigration. (*Attach copy of your Visa/Work Permit*)

6. Intended practice location in Arkansas: _____

Give name and address of hospital, clinic, group or private: _____

7. Board Certified:_____ Board Certified: _____
(Date) *(Date)*

Recertification:_____ Recertification: _____
(Date) *(Date)*

8. Drug Enforcement Administration Number:_____ State:_____ Expiration Date: _____

Submit a copy of your DEA registration number to this office.

9. UPIN:_____

Medicaid Provider Number:_____ Medicare Provider Number: _____

10. Professional Liability Insurance (Carrier Name): _____

11. Have you completed at least 90 hours of undergraduate studies? Yes____ No____

Name of Institution

12. Podiatric Medical Education

Date Graduated: _____
(Month/Day/Year)

Name of Institution	Address	Date From	Date To

Have all official transcripts mailed directly to this office

13. Residency/Fellowship:

Date Graduated: _____
(Month/Day/Year)

Name of Institution	Address	Date From	Date To

Have verification of education mailed directly to this office.

14. Have you successfully completed all parts of the National Board? ☐ Yes ☐ No

If yes, have certified copy of scores mailed to this office.

15. Have you ever taken the Arkansas State Board Examination? ☐ Yes ☐ No

Where: _____ When: _____

16. Continuing Medical Education:
List Continuing Medical Education for the last two (2) years excluding Residency/Fellowship training

Date	Description	Sponsor/Location	Hours

If you have additional specialized training, submit documentation.

17. Professional Activities:

List in chronological order all your professional activities, institutional affiliations, or places of employment since graduation from Podiatric Medical School. This includes hospitals, teaching institutions, managed care organizations, private practice, corporations, military assignments, government agencies and Locum Tenens assignments. Exclude Residency and Fellowship. You may attach additional sheets if needed.

From	To	Location and Complete Address	Position

Please review this list carefully. If there are gaps in your chronological history you are required to provide a brief explanation.

18. Military Service ☐ Yes ☐ No

If Yes, which Branch? _____ Dates of Service: _____

19. Podiatric Medical Societies and Professional Organizations:

Organization	Address	From	To

20. Professional Licenses:

List in all states/countries in which you have had a medical or professional license.

State	License Number	Date Issued	Active Y/N	State	License Number	Date Issued	Active Y/N

21. Professional References:

Have three (3) reference letters mailed directly to this office. These three (3) references may not be the current partners or related to you. They must have worked with you and directly observed your professional performance in the recent past. At least one of these references must have had an organizational responsibility for supervising your performance (i.e., department chief, service chief, or training program director).

Name	Address

Attach explanation of any "yes" answers.

22. ☐ Yes ☐ No Have you ever failed a licensing examination? Where? _____
Explain. _____

23. ☐ Yes ☐ No Has your application for examination or licensure in any state ever been rejected, denied or withdrawn?

24. ☐ Yes ☐ No Has any medical licensing board ever placed your license on probation, suspension or has it revoked a license or certificate it had granted you?
If yes, list name and address or board. _____

25. ☐ Yes ☐ No Have you ever been ordered to appear before any board for any reason other than licensure?

26. ☐ Yes ☐ No Have disciplinary procedures ever been initiated toward you by any medical board or hospital?

27. ☐ Yes ☐ No Have your privileges at any hospital been denied, suspended or diminished, voluntarily or involuntarily relinquished, revoked, or not renewed or is any such action pending?

28. ☐ Yes ☐ No Have you voluntarily surrendered your license in any state?

29. ☐ Yes ☐ No Have you ever been charged or convicted of a misdemeanor or felony?

30. ☐ Yes ☐ No Have you ever been denied provider participation in any Medicaid or Medicare program?

31. ☐ Yes ☐ No Have you ever previously made application to the Arkansas Board of Podiatric Medicine?

32. ☐ Yes ☐ No Have you ever been warned, censured by, or requested to withdraw from any hospital in which you have trained, been a staff member or held hospital privileges?

33. ☐ Yes ☐ No Have you ever been disciplined or dismissed from any professional activity or training program? Explain. _____

34. ☐ Yes ☐ No Have you ever, voluntarily or involuntarily, left a training institution program before completing it?

35. ☐ Yes ☐ No Have you ever been reported to the National Practitioners Data Bank (NPDB) or subject to a NPDB adverse action report?

36. ☐ Yes ☐ No Have you ever resigned or surrendered clinical privileges, from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted?

37. ☐ Yes ☐ No Have you been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending?

38. ☐ Yes ☐ No Have you ever been terminated, sanctioned, or penalized by any Medicaid or Federal Medicare programs? If yes, explain. _____

39. ☐ Yes ☐ No Have any malpractice claims been filed against you? If yes, provide official documentation from your attorney or insurance company.

a. How Many?
b. How many were dismissed with settlement? _____
c. How many were dismissed or dropped? _____
d. How many are pending? _____

40. ☐ Yes ☐ No Have you ever been cited by a peer review organization?

41. ☐ Yes ☐ No Have you ever had to discontinue practice for any reason for a period longer than one month.

42. ☐ Yes ☐ No Do you have any physical, mental or emotional impairments?

43. ☐ Yes ☐ No Have you ever been addicted to alcohol or drugs?

44. ☐ Yes ☐ No Have you ever had a DWQ/DUI? How many?_____Date(s) occurred: _____

45. ☐ Yes ☐ No Have you ever been treated for drug or substance abuse?

46. ☐ Yes ☐ No Are you currently being or have you ever been monitored by a Physician Committee in any state? If yes, ask your attending physician to send documentation of your status.

47. ☐ Yes ☐ No Have you ever been rejected by any medical society?

48. ☐ Yes ☐ No Has your license to practice any medical discipline or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending?

49. ☐ Yes ☐ No Have you ever defaulted on any Health Education Assistance Loan?

50. ☐ Yes ☐ No To your knowledge, are you currently the subject of an investigation by any licensing board as the date of this application?

If during this application process, you become aware of any such investigation, you are required to report it to this office.

AFFIDAVIT OF APPLICANT

I,_____, certify that after being duly sworn, that all of the information supplied in this application is true and correct to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in criminal prosecution to the fullest extent of the law and in the revocation or denial of any license to practice podiatric medicine granted to me.

Date: _____

_____
Applicant's Signature

County of: _____

State of: _____

SWORN to and subscribed before me this_____day of _____

SEAL

PHOTOGRAPH

_____
Notary Public

My Commission Expires: _____

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