Application for Renewal of License
Arkansas Board of Podiatric Medicine

Name:______________________________ License #: _____________ NPI #: __________________

Today's Date: _________________________

Practice Address: ________________________ Check here if currently not practicing

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Office phone: ________________________ Email: __________________________

Cell phone: ________________________

Address to send renewal if different than practice address:

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The State of Arkansas requires The Board to report the following information:

Place of birth: ____________________ Date of birth: _______________

Ethnicity: Hispanic/Non-Hispanic Gender: _______________

Race: ____________________ City of your practice: _______________

County of your practice: ____________________ Podiatric Medical school attended: _______________

The following information is mandatory. Any YES answers <u>since the last renewal</u> requires a <u>NOTARIZED, DETAILED STATEMENT.</u>

Since your <u>last</u> license renewal……….

	yes	**no**
1. Have you been the subject of disciplinary action by a governmental or licensing authority, federal, state, or local ?	________	________
2. Have you been charged with or convicted of a felony or Misdemeanor, federal, state, or local ?	________	________
3. Are you presently using any drug, or chemical substance including alcohol which has an adverse impact on your ability to practice your profession ?	________	________
4. Do you have a mental disorder which has an adverse impact on your ability to practice your profession ?	________	________
5. Have you been reported to the National Practitioner Data Bank (NPDB) ?	________	________
6. Have you voluntarily surrendered any medical license or Narcotic permit (state or federal) ?	________	________
7. Have you been denied privileges, lost privileges, or received discipline by any hospital or other professional medical organization ?	________	________
8. Has a malpractice claim been filed against you ?	________	________

***Signature:*____________________________** ***Date:* ___________**

Continuing Education Requirements

Twenty (20) hours of continuing education shall be required for the renewal of an individual license. These must be obtained in the twelve month period immediately preceding the year for which the license is to be issued. The hours approved must be from any of the following sources:

(A) The hour has been approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(B) The hour was obtained when attending official meetings presented by any State Podiatric Medical Association;

(C) The hour was obtained from meetings approved by the Council on Medical Education of the American Medical Association or approved by the Council on Osteopathic Medical Education of the American Osteopathic Association as long as the hours pertain to the practice of Podiatric Medicine;

(D) The hour was obtained from hospital lectures, as long as the hour pertains to the practice of Podiatric Medicine.

The Board will accept any “approved” hours, as that term is defined in paragraph 2 above, regardless of whether those hours are from meetings, the internet, or periodicals.

In addition to the methods of approval for continuing medical education hours provided in paragraph 2 of this Rule, the Board may consider prior approval of meetings. Such prior approval shall be obtained from the Secretary of the Board or, if the Secretary is unavailable to consider hours for approval, a designee of the Board appointed by the President of the Board.

Please submit proof of your CME's along with this renewal application.

Continuing Education Documentation

Title: ______________________________________ date: _____________

Location: ___________________________________ #hours: ___________

Title: ______________________________________ date: _____________

Location: ___________________________________ #hours: ___________

Title: ______________________________________ date: _____________

Location: ___________________________________ #hours: ___________

Title: ______________________________________ date: _____________

Location: ___________________________________ #hours: ___________

Title: ______________________________________ date: _____________

Location: ___________________________________ #hours: ___________

Total # of hours: ______________

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating The Arkansas Board of Podiatric Medicine. I hereby state the information contained in this renewal is true and correct. I understand this form is public information.

Signature:_____________________________ ***Date:*** ___________

** A renewal fee of **$4** is required with this renewal. Payment may be made in the form of a business check, personal check, cashier's check, money order, or bank draft.*

Please return the completed application and renewal fee to:

Arkansas Board of Podiatric Medicine
4815 West Markham St. Slot #1
Little Rock, Arkansas 72205-3867